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ISSUES RELATING TO MEDICARE HOSPITAL PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

MAY 14, 1985

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ISSUES RELATING TO MEDICARE HOSPITAL PAYMENTS

TUESDAY, MAY 14, 1985

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room B-318, Cannon House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[For immediate release, Friday, May 3, 1985]

HON. FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON ISSUES RELATING TO MEDICARE HOSPITAL PAYMENTS TO BE HELD ON TUESDAY, MAY 14, 1985

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on issues related to the medicare prospective payment system for hospitals on Tuesday, May 14, 1985. The hearing will begin at 10:00 a.m., and will be held in Room B-318 Rayburn House Office Building.

The Subcommittee wishes to receive testimony concerning the existing medicare payment arrangements for hospitals and various proposals for change, including the following:

The impact of the scheduled transition toward national DRG rates and away from hospital-specific prospective payment rates, in combination with the Administration's proposed hospital payment rate freeze;

Whether it would be advisable to delay this transition, now scheduled in existing law;

The advisability of implementing a new wage index and the related issue of the retroactive application of the new wage index as mandated by law:

Data on higher medicare costs associated with treating a disproportionate share of low-income patients, and the feasibility of, and methodology for, establishing an adjustment to compensate hospitals for such higher costs;

Proposals to reduce or eliminate the return on equity now included in the calculation of reasonable cost reimbursement for capital expenses; and

The adequacy of the prospective payment system in adjusting for case complexity and the relationship of case complexity with proposals for freezing the cost reimbursement amounts for direct medical education and for reducing or otherwise modifying the adjustment for indirect costs of medical education.

Oral testimony will be heard from *invited witnesses only*. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

INFORMATION FOR WITNESSES

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses invited to appear before the Subcommittee are asked to comply with the following requirements:

1. Witnesses should submit 5 copies of their written statement to the Health Subcommittee, 1114 Longworth House Office Building, no later than noon on Monday, May 13, 1985, and should provide at least 75 copies to the Main Committee Office, 1102 Longworth House Office Building, early on the morning of the hearing.

2. Each statement to be presented to the Subcommittee or any written statement submitted for the record should contain the following: (a) The name, full address, and capacity in which the witness will appear (as well as a telephone number where the witness or a designated representative may be reached); (b) A list of any clients or persons, or any organization for whom the witness appears; and (c) A topical outline or summary of comments and recommendations.

3. Witnesses should not read their written statements to the Subcommittee, but should instead limit their oral presentations to a summary of the points included in the statement. Witnesses are requested to limit their oral summaries to no more than five minutes.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by the close of business on Friday, May 24, 1985, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. (See other requirements under #2 above.) An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman **Stark**. The Ways and Means Subcommittee on Health will begin. We are meeting here today to try to learn what has happened in the months since Medicare began using the prospective payment system to reimburse hospitals for the inpatient care to Medicare patients. This change can only be termed revolutionary. It reversed the whole logic of an existing payment system that had been in use for nearly two decades.

For years hospitals could make money by spending money. As a general rule, higher costs could be translated into higher reimbursement. Under that system, keeping a patient hospitalized for more days was a very attractive idea. Now that's all been changed.

A hospital now receives a flat fee per diagnosis. If it can deliver care cheaper, it makes money. If it spends more than the stipulated amount, it loses money. The system has some quirks and it actually is a bit more complicated than that, but my summary accurately reflects its direction.

We're here today to learn how the new system is working. If patients are leaving the hospital sooner, we want to know whether that's good news or bad news. We want to know whether the amounts hospitals are receiving are appropriate and whether those who are thriving are doing it through the Government's good will or through their own expertise.

We need to know whether we should tinker with the system a bit as part of this year's budget debate in an effort to perfect it. I am afraid we are not going to get much light shed on alternatives this committee may have to face as a result of the budget process that is going forward on Capitol Hill. And I would ask all the witnesses as they present their testimony to try and give us alternatives.

To sit and testify today as if no change will be made in the face of the administration asking us to cut $19 billion out of the budget in the next 3 years is naive. To think any one group is going to escape scrutiny, again, is naive. So testimony that just says give us more or continue the old system isn't going to be of much help to us, I am afraid.

Testimony that will give us preferences, with the understanding that cuts in medical care are never desirable, from certain groups' point of view, may be necessary. So that I would ask the witnesses to be as direct as they can. I, too, with the exception of our colleagues in the administration, am going to hold the witnesses to a 5-minute summary of their written testimony.

I intend to be somewhat more generous with members of the committee who may want to explore the written testimony in more detail, and I think through the inquiries of the committee members, we will get more meaningful dialog than if we sit and listen to you all read excellently prepared testimony, which we can read six times as fast as you can read it out loud.

If any of the members don't have enough chance to explore the testimony, we will go around a second time. Somebody up here has a timer. She should be somebody in a black and white striped shirt. We have signs that will indicate when you have a minute remaining, and I hope that all the witnesses will cooperate.

I am happy to have Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. Chairman, I can't restrain from saying just a few things when I see the size of the turnout this morning. The reason I say that is because I think it indicates very clearly that the new reimbursement system has created new classes of people and institutions which perceive themselves as winners and losers and are here to petition us for changes in this program which will aid their cause.

Under the old system, when there was the problem, we just put more money into the program. With the new DRG system, we are basically working with a closed pool of funds. It is a zero sums game. What that suggests is that the future of the reimbursement system really hangs in the balance, and a lot of whether it succeeds or fails is going to depend upon the sensitive task which lies before this subcommittee and the full committee in attempting to balance the equities and interests of those represented here today.

So, Mr. Chairman, I just would like to thank you for scheduling this hearing, and in advance thank the excellent panels of witnesses who have appeared to give us their recommendations.

Chairman **Stark**. Thank you, Mr. Gradison. I must add that not only are there perhaps new interests because of this system, but I have also found in my new job that I have new organs that I didn't know I had, and each of them is represented by somebody in this room. Humana has offered to install them in me at any time, and let me charge it on my VISA card. So I find as we change the system many wondrous things appear.

Perhaps the most wondrous among them is my colleague and neighbor from California, the Honorable Bob Matsui from Sacramento. Bob, would you like to proceed?

STATEMENT OF HON. ROBERT T. MATSUI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Matsui**. Thank you, Mr. Chairman and members of the subcommittee for this opportunity to share with you my views on issues surrounding the Medicare prospective payment system.

Over 18 months ago, we began a bold and exciting period in the history of Medicare. We threw out the cost-based payment system for hospitals and inaugurated a prospective pricing system based on the average cost of a Medicare hospital admission. In a very short period, the effects of this change in payment policy on the hospital system and on Medicare patients have been profound.

Let me say at the outset that I very strongly support the legislation establishing a prospective payment system for Medicare hospital services. The incentives of the retrospective cost payment method produced a substantial amount of inefficiency in our hospital system and penalized those institutions that sought to be cost-effective. Under cost reimbursement, our hospital system expanded too rapidly and produced an expenditure level that could not be supported.

Prospective payment by Medicare combined with more prudent purchasing practices by Medicaid and private health plans have begun to alter historic growth trends and to change the way we use hospital services. Hospital costs increased just 4.5 percent in 1984 as compared to rates of 10.2 and 15.8 percent in 1983 and 1982 respectively. Hospital admissions dropped by 4 percent and average occupancy stands at 66 percent. Length of stay for Medicare patients dropped to 7.5 day down 2 full days from the average in 1983.

These statistics are unprecedented. In fact, they are cause for us to examine carefully the implications of the vast changes in progress so as to avoid any deleterious effects on the quality and accessibility of hospital care. For those of us in Congress with the responsibility for oversight for the policies we set in motion, I believe the time has arrived for us to examine the prospective payment system to assure that it is operating fairly and that we are not doing avoidable harm to our hospitals and the patients they serve.

When we designed the PPS legislation in 1983, we understood that it was an imperfect system and that we would need time to make refinements and improvements before it became fully effective. A 3-year transition period was adopted allowing a gradual movement from prices based on hospital-specific data to national average prices. At the same time, we called on the Secretary of Health and Human Services for a series of studies to provide the basis for further adjustments that would account for severity of illness differences, for the higher costs of hospitals serving a large volume of Medicare and low-income patients, and for the variations in area labor costs.

We are at the midpoint in our transition to a national pricing system. We find, however, that much of the research agenda we set up has yet to be completed. Studies are still in progress and virtually none of the expected refinements to PPS have been implemented. Complicating this situation is the enormous Federal deficit that requires us to consider further cuts in Medicare hospital outlays. These additional cuts in PPS payments are not the result of refinements that make the system more equitable or more accurate. Instead, they are reductions based upon budgetary considerations. And the urgency of this issue is heightened further by the proposals to freeze PPS prices and to reduce substantially payments for medical education.

What is particularly of concern is the recent evidence supporting the need for reform of the PPS. The Prospective Payment Assessment Commission [ProPAC] recently issued its first annual report including some 21 specific recommendations for improvement of PPS. A number of private organizations and researchers have also produced reports that identify operational deficiencies and inequities in the present system. It seems unlikely, at this point, that many of these flaws will be corrected before PPS is fully implemented.

Among the more serious problems with PPS is the failure to distinguish differences in the severity of illness within the same diagnostic category. Thus, the same price is paid for cases that may have very different resources applied during a hospital episode. If a hospital happens to attract patients with above average costs in a particular diagnostic category, then its Medicare payment is consistently below the costs of providing care to its mix of patients. Without a means of adjusting for these variations in costs within DRG's, there is a systematic bias against hospitals treating the more seriously ill patients.

Another problem of the present system is its lack of sensitivity to variations in the costs of labor and other goods and services purchased in local markets. Recent studies have shown significant variations in labor costs between inner-city hospitals and those in suburban areas, and between rural areas within the same State. These differences are not reflected in the current area labor adjustments. Likewise, the costs of supplies and services vary greatly from area to area making a national market basket adjustment less than adequate for area differences in the costs of doing business.

Finally, under PPS no adjustment is now made for hospitals treating large numbers of Medicare and low income patients, despite studies showing such hospitals to have higher Medicare costs. While Congress has specifically directed implementation of such an adjustment on two occasions, no action on this problem has been taken.

What we are beginning to see with this imperfect system is large "windfall" payments to hospitals in certain geographic areas and significant underpayments to similar hospitals in other areas. In short, the current payment system with these major problem areas will arbitrarily distort the distribution of available Medicare funds. It essentially takes dollars from losing hospitals and gives them to others with little, if any, reason other than geographic location. Furthermore, projections reveal that if Medicare's payment rates are frozen and the allowance for the cost of indirect medical education is halved during fiscal year 1986, hospitals will lose over $2.7 billion in payments for treating Medicare beneficiaries. Hospitals in my home State of California become losers of almost $370 million.

I am concerned about these payment variations because I suspect the differences are to solely related to the efficiency or lack of it in hospital operations. Instead, it appears that we are facing the beginning of a payment system that forces medical decisions on financial considerations alone and rewards winners and penalizes losers on all the wrong criteria.

The continued transition to payment rates based on national averages in light of these flaws and distortions will unfairly penalize and, in some cases, threaten the financial viability of many of our community hospitals. And worse, it will raise the question of access to necessary health care services and will cause us to reconsider health care as a privilege and not as a basic right, as has been the overwhelmingly popular expectation of the American public.

The basic purpose of the Medicare Program has been to ensure the access and availability of necessary health care services to older Americans regardless of their existing medical conditions and regardless of the limitations of their income. It is my hope that we do not allow the current PPS system to threaten this mission.

In the absence of more refined and precise adjustments to hospital prices, it is difficult to support continuation of the scheduled transition to national prices. Such a transition could only exacerbate the distortions present in the system today and lead to unnecessary and, in some cases, irreparable damage to our hospital system.

Therefore, I have introduced legislation that would permit us the opportunity to improve PPS during a pause in the scheduled transition to a national rate. Under H.R. 1953, the present price blend, 50 percent hospital specific and 50 percent Federal average, would be maintained for another year or for as long as the present DRG prices are frozen. Prior to December 31, 1986, the Secretary of HHS and ProPAC shall report to Congress on revisions to PPS that should be adopted before the system is fully implemented. Their reports should address:

The wide variations in the use of hospital resources by patients within the same DRG.

The inequities that result from reliance on a national market basket as an inflation index for DRG prices.

The arbitrary effects of geographical boundaries on payment amounts.

The most accurate method of recognizing the indirect costs of graduate medical education.

And the need for a payment adjustment to hospitals serving a disproportionate number of Medicare or low-income patients.

This legislation grows out of my commitment to prospective payment and my desire to ensure its equitable and effective operation. I believe that this period of stability and payment predictability will allow Congress and the administration to thoroughly evaluate these and other problem areas and take corrective action.

Furthermore, since the extension of the transition period will have absolutely no effect on the amount of total Medicare inpatient payments—rather affecting only its distribution—this cautionary approach will not affect Congress' efforts to reduce the budget deficit. Rather this approach will provide for a fair evaluation of PPS, and gives us greater confidence that no hospital is either penalized or rewarded on any other basis than its operational performance. We can really do no less for our hospital system and the millions of Medicare beneficiaries who rely on it.

Mr. Chairman and members of the committee, I would be happy to answer any questions you may have.

Chairman **Stark**. Thank you, Bob. I am concerned about the prospective payment system and the transition as are you. I am afraid we disagree on the method to resolve it. In your bill you freeze the system for as long as the DRG prices are frozen. If we take the freeze off DRG prices, then you don't care whether the transition continues. What happens in your bill? Does that automatically stop the freeze? Do we proceed to 75, then 100 percent?

Mr. **Matsui**. No, Mr. Chairman. I would frankly like to have this pause which I hope would be less than 1 year, implemented only to give HCFA and the industry and others an opportunity to come up——

Chairman **Stark**. That is just not realistic. HCFA is years behind in reports that have been mandated by this committee. No, any objection is if we proceed along the idea of a freeze what we are really doing is voting up or down on a 50/50 split, with no more indication that that is the proper amount than anything else.

The hospitals, HCFA, everybody has the information. They have known this is coming for a year. And nobody has seen fit to bring the information forward. I for one am going to say I am willing to change it. But I am not willing. We have watched fringe benefits become frozen and put it off year after year. So we fiddled with that for 6 years.

I am just afraid what we are saying is you vote for a freeze, you are voting for 50-50 forever with no more information or reason for doing that than the system we are in now. So I am urging people who are upset, and there are, in my own home State, which I am not insensitive to, the great State of Illinois. And we will hear from another colleague on that, but I am no more sure 50-50 is right as whether 25-75 is right.

We have the time. So I am going to urge the people who want to freeze the transition to come forward and let's have a hearing and change it, but a freeze to me is shirking our legislative responsibilities. And let's get the system done right.

Mr. **Matsui**. Mr. Chairman, may I respond?

Chairman **Stark**. If HCFA isn't going to give us the information, let's get our own. Sure.

Mr. **Matsui**. It was about a month and a half ago, I believe, in early March or late February, when you held a hearing and you asked the Administrator of HCFA, Carolyne Davis, to give a number of reports that are due. I believe there were some 20 reports, at least five or six that were very important, indigent care, how you deal with that; the wage index; differences of amounts paid on the basis of hospital specific or regional differences. All these report are due.

When we passed the legislation in April 1983 to implement prospective payments, we all assumed that before national rates would be implemented we would have the reports in hand so we could evaluate the system and make adjustments should they be necessary as time went on. Thus, far as you have indicated, we have not received these reports from HCFA.

We have asked the Administrator from HCFA to give us the information.

Thus far she has made no commitments, but I think your comments of a few months ago and Mr. Gradison's will be very helpful in getting us this information. I honestly believe that this pause would be very useful because we will get these reports within the timeframe. Let me mention another thing, too. This isn't, in my opinion, a fight between hospitals. The reason I am involved in this issue and I think the reason Mr. Porter and other members are behind the bill is mainly because we are concerned about the quality of care for patients.

We have now seen an impact upon the private sector, Blue Cross et cetera. There is a squeeze on the hospitals there. We have seen a squeeze on Medicaid. In California alone we have the contracting out approach. We have also put on the squeeze because of prospective payments and the freeze on Medicare. I think this is all very good. We are all, I think, finally realizing we have to get the cost of health care reduced in this country. And we have to begin to reduce costs.

At the same time, what we are seeing, and the experience rate is just beginning to occur, are a lot of people falling off the edges. People that don't have Medicaid, Medicare or any employer-based health insurance now are not getting treatment. I was at a meeting with a number of supervisors from California. They mentioned to me that they can't take patients in their hospitals, their county hospitals because they can't afford to at this time because of the constraints of Proposition 13. So I think we are seeing this situation occur.

My concern is that we are supposed to get information from HCFA in this area—we haven't received it. I am afraid if we continue the implementation and movement in the national rates we are going to find we are going to create great damage to a lot of people and harm in a significant way our hospital system, in fact our health system today without really knowing what we are doing in this area.

That is why I support this pause. We are not trying to stop prospective payments. We are not trying to destroy what we did in 1983. We are just trying to refine it to make sure it works the way we want it to work.

Chairman **Stark**. What we can answer is whether going to 75–25 might be better.

Mr. **Matsui**. Mr. Chairman, I did offer that last year.

Chairman **Stark**. You think 50–50 is better, but we don't know either way. Mr. Gradison?

Mr. **Gradison**. Mr. Chairman, I have a question for my colleague having to do with the various reports which he has asked about. My basic question is if we follow your recommendations wouldn't they push us back to largely an institution specific reimbursement system which is what we are trying to get away from?

You make a particular point, and understandably so in your statement about the lack of sensitivity to variations in the cost of labor and other goods and services purchased in local markets. You also mention, very properly, the arbitrary effects of geographical boundaries on payment methods and so forth. Can we really, if we focus on this, accomplish what you are talking about without having the bulk of the reimbursement pretty much based upon what an individual institution pays for wages and pays for supplies which is back toward a cost-based reimbursement system?

Mr. **Matsui**. Well, I believe what you are asking is if the reports come out and say, yes, there is a variation in hospital costs, one, the hospitals can't deal with, and if there is a difference in regional areas such as an urban or inner city or suburban area, and if there is a cost of supplies difference, we may never go to a national rate.

Mr. Gradison, I say, yes, that may well be. I am not suggesting that there is any magic in 100 percent national rate, no more than I am suggesting the old system is an adequate system. It may not be possible to deal with it in 3 years. It may take 10 years in order to eliminate disparity between what the cost of a nurse in Georgia would be as opposed to the cost of a nurse in Los Angeles.

But I am saying we ought to find that out because in April 1983 when we passed PPS, we assumed that these variations would be eliminated within a period of 3 years. I think looking back on that, that is unrealistic. But by my making that statement, I am not suggesting for a moment we ought to junk PPS. I think we ought to see how far we can go on to national rates. There may be a point where we can't do it. We ought to see as far as we can go.

Mr. **Gradison**. Thank you.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Mr. Matsui, I think most of us would agree the DRG rates are working reasonably well. In all the regions the hospitals are in better shape than they have been in years. In the absence of any kind of freeze on DRG rates, I don't know that we are going to do that or recommend that at all. But with them doing well, what is the justification in delaying the national rates?

Mr. **Matsui**. Mr. Pickle, I don't know how the hospitals are doing in Texas. They may be doing quite well. We have heard from hospitals in California, Illinois, Ohio, Wisconsin, Michigan, Massachusetts, just to name six States—

Mr. **Pickle**. Mr. Matsui, that may be true. But in all the regions I believe the reports are that their hospitals are doing better. Individual hospitals may not, but by and large in every region they are doing well now. If that is a fact, without going to individual hospitals, why should we delay the national rate?

Mr. **Matsui**. I think because Mr. Pickle, individual hospitals are important—it is a very important issue—

Mr. **Pickle**. I am not arguing that point. I see you have to look at the individual hospital, but you also have to look at the overall picture with respect to regions. I will address the question later to Dr. Davis and other officials because I think we have got to look at the national picture as well.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. I really appreciate our colleague on the committee bringing his insight to us. I am particularly concerned about the wage index, and I think I am going to reserve my time for that and just thank the gentleman for being here today and engaging in this exciting and lively kickoff to a very serious problem.

Mr. **Matsui**. Thank you, Mr. Daub.

Chairman **Stark**. Mr. Gregg.

Mr. **Gregg**. I would just like to say every time I turn around I run into Mr. Matsui. He seems to be on top of every issue. I would like to know how he does it. I appreciate him being here.

Chairman **Stark**. I would like to welcome the distinguished ranking minority member of the full committee, Mr. Duncan.

Mr. **Duncan**. Thank you. I have no questions. Thank you.

Mr. **Matsui**. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Porter, who was scheduled to testify had a conflicting appointment. He will return, and we will welcome him when his schedule permits.

Chairman **Stark**. Our next witness is Dr. Carolyne K. Davis, Administrator of HCFA.

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ALLEN DOBSON, DIRECTOR, OFFICE OF RESEARCH, AND CHARLES BOOTH, DIRECTOR, OFFICE OF REIMBURSEMENT POLICY

Ms. **Davis**. Good morning, Mr. Chairman.

Chairman **Stark**. Welcome to the committee, Dr. Davis. You may proceed with your statement.

Ms. **Davis**. Thank you, Mr. Chairman. I am pleased to be here to discuss our progress in implementing Medicare prospective payment for hospitals. Accompanying me is Allen Dobson, Director of the Office of Research. On my left is Mr. Charles Booth, Director of the Office of Reimbursement Policy.

As we pass the midpoint to a fully national system, the results have been highly positive, I believe. Hospitals have responded to the challenge by adopting cost-effective practices. Monitoring the practices are the professional review organizations and they indicate continuation of high quality of care. I think it is a tribute to cooperation among the hospitals and medical professions, intermediaries, Federal Government and all interested parties that the implementation of the PPS has really gone quite smoothly.

Success of the implementation to date would indicate the transition to fully national rate should continue as scheduled. I believe failure to continue the transition could undermine confidence in the prospective payment system. There are absolutely no significant problems we can determine that would warrant a slowdown, and the slowing of the transition, we believe, would reward those hospitals that are traditionally higher cost at the expense of hospitals that have become efficient and have lower costs.

I would point out, too, Congress deliberately specified a 3-year phase-in in order to allow higher cost hospitals to make the transition. Our legislative and regulatory proposals for fiscal year 1986 are of course an integral part of efforts to refine the system. Our proposed maintenance of payment sets fiscal year 1986 rates at 1985 levels. We believe this has a sound programmatic base. Contributing factors are the hospital market basket, the case mix and productivity changes.

Our proposed notice rulemaking scheduled to be published June 3, will discuss these factors in greater detail. We would establish a maximum limit of allowable passthrough costs for approved educational programs in order to encourage hospitals to target resources to activities most appropriate to their patients and the community. We would eliminate doubling of the factor which provides an add-on to prospective payment for the indirect medical costs since there is no empirical evidence to justify the doubling.

We are continuing analysis and research in other areas where we believe refinements are necessary and needed. In March we released a report describing alternative wage indexes which might be used to modify the PPS rate to reflect local wage levels. The HCFA-developed indexes address a problem with the current index which fails to distinguish between full and part-time workers.

Current law requires that if a revised index is adopted it must be implemented retroactively to October 1, 1983. Since implementation could result in substantial overpayments and disruptions to some hospitals, we have been soliciting comments and recommendations from all interested parties before we reach a final decision in that area.

We are continuing to study the issues of how to define hospitals which serve a disproportionate share of low income patients and Medicare beneficiaries. The initial data we looked at from a 2-week survey from the Office of Civil Rights in 1982 proved to be extremely flawed. We are currently seeking other sources of data and are exploring the use of ZIP codes as a proxy for identifying patients who live in low income areas. This is a high priority project.

The disproportionate share issue may be somewhat less critical as we identify in the longer run methods to better measure the severity of illness within the DRG system. We are currently reviewing systems for predicting that type of resource use and refining our data base to permit comparisons between the various indexes.

Over the long run we will attempt to identify hospitals that regularly treat sicker patients and we will seek ways to adjust the DRG system in light of changing technologies. Finally, we will test case mix systems which measure those variables that are found to be significant.

The Department is currently preparing a congressionally mandated study of how to include capital costs which are now reimbursed outside the prospective payment system. That study will contain the entire range of capital reimbursement issues, and until it is completed——

Chairman STARK. When do you expect we will see that study? It was due October of 1984. Can you tell us when we will have the study.

Ms. DAVIS. I cannot speak for the Department in that relationship. I believe it did send forward about six chapters of the study and that the final chapter of the study with the recommendations is still in departmental discussion.

Chairman STARK. Would you have any objection to us looking at the first six chapters and wait for the recommendations?

Ms. DAVIS. I believe they were sent—my staff tells me there were several volumes that were sent.

Chairman STARK. These are background studies you have contracted out?

Ms. DAVIS. Yes.

Chairman STARK. But we have nothing from the Department.

Ms. **Davis**. That's right. Mr. Chairman, that concludes my summary. I would be happy to answer any questions.

[The prepared statement follows:]

Statement of Carolyne K. Davis, Ph.D., Administrator, Health Care Financing Administration

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM PLEASED TO BE HERE TO DISCUSS THE IMPLEMENTATION OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM (PPS)--ITS SUCCESSES, ITS CONTINUING CHALLENGES AND OUR PLANS FOR THE FUTURE. ACCOMPANYING ME TODAY ARE ALLEN DOBSON, DIRECTOR, OFFICE OF RESEARCH AND CHARLES BOOTH, DIRECTOR, OFFICE OF REIMBURSEMENT POLICY.

BACKGROUND

MEDICARE'S PPS IS PROBABLY THE SINGLE MOST IMPORTANT IMPROVEMENT IN THE MEDICARE PROGRAM SINCE IT BEGAN IN 1966. FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY SINCE WE REIMBURSED BASICALLY WHATEVER COSTS WERE INCURRED. UNDER PPS, WITH THE AMOUNT OF PAYMENT SET IN ADVANCE AND BASED ON THE PATIENT'S DIAGNOSIS, HOSPITALS WHICH ORGANIZE AND PROVIDE SERVICES IN AN EFFICIENT AND COST-EFFECTIVE MANNER ARE REWARDED. OVER THE LONG RUN, PPS SHOULD PROVE TO BE A VALUABLE WEAPON IN OUR BATTLE TO CONTROL THE RISE OF HEALTH CARE COSTS WHILE ASSURING ADEQUATE ACCESS AND QUALITY CARE FOR OUR PROGRAM BENEFICIARIES.

AS WE MOVE INTO THE SECOND HALF OF FISCAL YEAR 1985, THE SECOND YEAR OF A PHASE-IN FROM A BLEND OF REGIONAL AND HOSPITAL SPECIFIC RATES TO A FULLY NATIONAL

PROSPECTIVE RATE, WE CAN TAKE PRIDE IN THE SMOOTHNESS OF IMPLEMENTATION TO DATE. THIS SUCCESS IS A REAL TRIBUTE TO THE COOPERATION OF HOSPITALS, FISCAL INTERMEDIARIES AND OTHER ORGANIZATIONS WHO HAVE WORKED SO CLOSELY WITH US IN THIS EFFORT. A TOTAL OF 5,405 OR 81 PERCENT OF ALL MEDICARE CERTIFIED HOSPITALS ARE NOW ON PPS AND ABOUT 83 PERCENT OF ALL PAYMENTS FOR INPATIENT HOSPITALS SERVICES IN FISCAL YEAR 1985 HAVE BEEN UNDER PPS.

CHANGES IN HOSPITAL BEHAVIOR TO ADJUST TO THE NEW SYSTEM HAVE BEEN POSITIVE. REDUCTIONS IN LENGTH OF STAY HAVE MODERATED THE AMOUNT OF RESOURCES NEEDED TO PROVIDE ROUTINE CARE. THERE IS ALSO EVIDENCE OF A DECREASE IN ANCILLARY SERVICES AND DEVELOPMENT OF MORE COST EFFECTIVE METHODS OF PROVIDING SERVICES INVOLVING HIGH TECHNOLOGY PROCEDURES. OUR MONITORING OF HOSPITAL BEHAVIOR THROUGH PROFESSIONAL REVIEW ORGANIZATIONS INDICATES THAT BENEFICIARIES ARE CONTINUING TO RECEIVE HIGH QUALITY CARE.

TRANSITION PERIOD

THE POSITIVE RESULTS OF PPS CONVINCE US THAT THE THREE YEAR PERIOD OF TRANSITION TO A FULLY PROSPECTIVE PAYMENT RATE SHOULD CONTINUE AS SCHEDULED. DURING FISCAL YEAR 1984, THE FIRST YEAR OF PPS PHASE-IN, HOSPITALS WERE PAID A RATE OF WHICH 75 PERCENT WAS

BASED ON A HOSPITAL'S HISTORICAL COSTS (THE HOSPITAL-SPECIFIC RATE) AND 25 PERCENT WAS A FEDERAL RATE BASED ON A REGIONAL RATE. DURING FISCAL YEAR 1985, THE PAYMENT IS 50 PERCENT HOSPITAL-SPECIFIC AND 50 PERCENT A FEDERAL RATE WHICH IN TURN IS 75 PERCENT A REGIONAL AVERAGE AND 25 PERCENT A NATIONAL AVERAGE. IN FISCAL YEAR 1986, THE SCHEDULED THIRD YEAR OF THE PHASE-IN, THE RATE WILL BE 25 PERCENT HOSPITAL-SPECIFIC AND THE REMAINING 75 PERCENT WILL BE BASED HALF ON A REGIONAL RATE AND HALF ON THE NATIONAL AVERAGE. IN FISCAL YEAR 1987, A FULLY NATIONAL RATE WOULD BE BASED SOLELY ON THE NATIONAL URBAN AND RURAL AVERAGES. ALL URBAN AND RURAL FEDERAL RATES ARE, OF COURSE, ADJUSTED FOR AREA WAGE LEVELS.

AS WE SIMULTANEOUSLY UNDERTAKE REGULATORY ACTIONS TO HOLD THE LINE ON PROSPECTIVE PAYMENT RATES, SOME CONCERNED PARTIES HAVE SUGGESTED THAT THE TRANSITION BE TEMPORARILY HALTED OR MODIFIED TO PERMIT SOME PORTION OF THE PAYMENT TO BE BASED ON HOSPITAL SPECIFIC COSTS INDEFINITELY. WHILE WE, TOO, ARE CONCERNED THAT HOSPITALS RECEIVE FAIR COMPENSATION FOR THE SERVICES PROVIDED, WE DO NOT BELIEVE THAT SLOWING THE TRANSITION TO FULL NATIONAL RATES WOULD BE A WISE MOVE. SUCH ACTION COULD BE INTERPRETED AS A LACK OF CONFIDENCE IN PPS, THEREBY UNDERMINING THE SPIRIT OF

COOPERATION WHICH HAS FACILITATED THE IMPLEMENTATION EFFORTS. IT WOULD CONTINUE HIGHER PAYMENTS TO HISTORICALLY HIGHER COST HOSPITALS AT THE EXPENSE OF THOSE HOSPITALS AND GEOGRAPHIC REGIONS WHICH ARE PROVIDING CARE IN A MORE COST EFFECTIVE MANNER. THE FULL NATIONAL RATE REFLECTS THE ORIGINAL PURPOSE FOR PPS AND THE INTENT OF CONGRESS THAT RATES REFLECT RESOURCE CONSUMPTION AND THAT HOSPITALS BE TREATED ON EQUAL BASES. FURTHER, AS I SHALL DISCUSS LATER, WE BELIEVE THAT OUR RATE PROPOSALS DO PROVIDE FAIR COMPENSATION. NO PROBLEMS HAVE OCCURRED THAT WOULD INDICATE A NEED TO DEVIATE FROM THE ORIGINAL PHASE-IN SCHEDULE.

CURRENT INITIATIVES

WHEN I APPEARED BEFORE THIS SUBCOMMITTEE IN APRIL, I REVIEWED OUR LEGISLATIVE AND REGULATORY PROPOSALS DESIGNED TO SLOW THE INCREASE IN MEDICARE EXPENDITURES IN FISCAL YEAR 1986. I WOULD LIKE TO TOUCH BRIEFLY AGAIN ON THOSE AFFECTING PPS AS THEY ARE AN INTEGRAL PART OF OUR OVERALL EFFORTS.TO REFINE THE SYSTEM.

WE PROPOSE TO MAINTAIN THE FISCAL YEAR 1986 PPS RATES AT FISCAL YEAR 1985 LEVELS. IN DEVELOPING THE PROPOSED PPS RATES, WHICH ARE SCHEDULED FOR PUBLICATION ABOUT THE FIRST OF JUNE, WE HAVE ANALYZED RECENT DEVELOPMENTS IN THE ECONOMIC CLIMATE OF THE HOSPITAL INDUSTRY WHICH WOULD AFFECT THEIR FINANCIAL VIABILITY UNDER PPS. SPECIFICALLY, WE REVIEWED THE PROJECTED AND ACTUAL

HOSPITAL MARKET BASKET WHICH MEASURES THE COST OF GOODS AND SERVICES USED BY HOSPITALS, THE EFFECT OF CASE-MIX CHANGES ON THE AMOUNT OF MEDICARE PAYMENTS FLOWING TO HOSPITALS, INCREASES IN PRODUCTIVITY AND SIMILAR FACTORS. OUR ANALYSES INDICATE THAT THERE ARE SOUND PROGRAMMATIC REASONS FOR MAINTAINING THE PPS RATES AT FISCAL YEAR 1985 LEVELS. WE ARE CONVINCED THAT THE LACK OF AN INCREASE WILL NOT FINANCIALLY DISADVANTAGE EFFICIENTLY MANAGED HOSPITALS.

OTHER BUDGET PROPOSALS AFFECTING PPS INCLUDE A REGULATORY REVISION WHICH WOULD LIMIT THE MAXIMUM AMOUNT OF ALLOWABLE DIRECT COSTS OF APPROVED EDUCATIONAL ACTIVITIES. THE LIMIT WOULD BE BASED ON THE LESSER OF A HOSPITAL'S ALLOWABLE COSTS OF THESE ACTIVITIES DURING ITS CURRENT COST REPORTING PERIOD OR DURING A BASE YEAR. THESE HOSPITAL EXPENSES ARE CURRENTLY REIMBURSED ON A RETROSPECTIVE COST BASIS OUTSIDE THE PPS WHICH DOES NOT ENCOURAGE EFFICIENCY IN OPERATING APPROVED PROGRAMS. UNDER THIS POLICY, HOSPITALS WILL BE ENCOURAGED TO TARGET THEIR RESOURCES TO THOSE TEACHING ACTIVITIES WHICH ARE MOST APPROPRIATE FOR THEIR PATIENTS AND THE COMMUNITY IN WHICH THEY ARE LOCATED.

MEDICARE ALSO REIMBURSES TEACHING HOSPITALS AN ADDITIONAL AMOUNT WHICH RECOGNIZES HIGHER INDIRECT

COSTS ASSOCIATED WITH TEACHING ACTIVITIES. SEVERAL YEARS AGO, HCFA DEVELOPED A FORMULA FOR DETERMINING HOW INDIRECT COSTS OF HOSPITALS INCREASED IN RELATION TO THE RATIO OF INTERNS AND RESIDENTS TO BEDS. THIS PERCENTAGE, CURRENTLY 5.795, WAS DOUBLED BY CONGRESS AND SPECIFIED AS AN ADDITIONAL PAYMENT IN THE LEGISLATION WHICH ESTABLISHED THE PPS. SINCE THERE IS NO EMPIRICAL BASIS FOR DOUBLING THE FORMULA, WE BELIEVE THE SUBSTANTIAL PAYMENTS TO TEACHING HOSPITALS RESULTING FROM THAT ACTION SHOULD BE DISCONTINUED.

AN INDIRECT TEACHING ADJUSTMENT RECOGNIZES, AMONG OTHER FACTORS, THAT TEACHING HOSPITALS MAY TREAT SICKER PATIENTS WITH ASSOCIATED HIGHER COSTS. WE HAVE UNDERTAKEN A COMPREHENSIVE RESEARCH EFFORT ATTEMPTING TO DEVELOP A SYSTEM WHICH WILL RECOGNIZE DIFFERENCES IN SEVERITY OF ILLNESS IN PATIENTS WITH SIMILAR DIAGNOSES. IT HAS BEEN SUGGESTED THAT ANY CHANGE TO THE LEGISLATED INDIRECT TEACHING ADJUSTMENT SHOULD AWAIT THE DEVELOPMENT OF SUCH A SEVERITY ADJUSTMENT. WE DISAGREE. THE FORMULA DEVELOPED BY HCFA WAS BASED ON RECOGNIZED INCREASES IN ACTUAL COSTS OF HOSPITALS WITH TEACHING PROGRAMS, WHICH INCLUDE COSTS ASSOCIATED WITH SICKER PATIENTS. THEREFORE, PRIOR TO THE LEGISLATED DOUBLING, THE INDIRECT TEACHING ADJUSTMENT ALREADY RECOGNIZED THOSE COSTS.

FUTURE DEVELOPMENTS

WHILE WE ARE HIGHLY OPTIMISTIC ABOUT THE CONTINUED VIABILITY OF PPS, WE ARE ACTIVELY CONTINUING ANALYSIS AND RESEARCH WHICH WILL PERMIT US TO REFINE THE SYSTEM, BY RECOGNIZING AND ADJUSTING FOR APPROPRIATE VARIATIONS IN THE COST COMPONENTS OF THE PPS RATES. I WOULD LIKE TO DISCUSS SOME OF THESE ACTIVITIES IN WHICH YOUR SUBCOMMITTEE HAS EXPRESSED PARTICULAR INTEREST.

ON MARCH 28, THE SECRETARY SUBMITTED TO CONGRESS A REPORT DESCRIBING ALTERNATIVE WAGE INDEXES FOR MODIFYING THE PPS RATES TO REFLECT LOCAL WAGE LEVELS. THE ALTERNATIVE INDEXES, DEVELOPED FROM DATA DRAWN FROM A SPECIAL ONE-TIME SURVEY OF ALL PPS HOSITALS, SPECIFICALLY ADDRESS A PROBLEM IN THE CURRENT AREA WAGE INDEX (BASED ON DATA SUPPLIED BY THE BUREAU OF LABOR STATISTICS (BLS)) WHICH FAILS TO DISTINGUISH BETWEEN FULL AND PART TIME WORKERS. ONE ALTERNATIVE INDEX IS BASED ON WAGES OF ALL HOSPITAL WORKERS AND THE OTHER EXCLUDES WAGES OF PHYSICIANS, RESIDENTS, INTERNS, CONTRACT WORKERS AND CERTAIN WORKERS NOT ENGAGED IN PATIENT CARE. THE REPORT INCLUDES A COMPREHENSIVE COMPARISON OF THE EFFECTS OF EACH INDEX ON PAYMENTS IN EACH OF THE METROPOLITAN STATISTICAL AREAS (MSAS) AND RURAL AREAS.

WE ARE SEEKING INPUT FROM CONGRESS AND OTHER INTERESTED GROUPS REGARDING WHETHER EITHER OF THE NEW INDEXES SHOULD BE SELECTED TO REPLACE THE CURRENT INDEX. SINCE THE WAGE INDEX MEASURES WAGES IN ONE AREA IN RELATION TO OTHER AREAS, WHENEVER ONE AREA INCREASES ANOTHER MUST DECREASE. SINCE THE LAW REQUIRES THAT ANY REVISED INDEX BE APPLIED BEGINNING IN FISCAL YEAR 1984, WE MUST CONSIDER NOT ONLY THE FUTURE IMPACT OF A REVISED INDEX BUT ALSO THE RETROACTIVE IMPACT AND ITS EFFECT PARTICULARLY ON THOSE AREAS WHERE OVERPAYMENTS MUST BE RECOVERED. IF A NEW WAGE INDEX WERE IMPLEMENTED RETROACTIVELY WE ESTIMATE THAT SOME METROPLITAN AREAS WOULD HAVE TO PAY BACK OVER $13 MILLION. THIS WOULD CLEARLY IMPOSE A SEVERE HARDSHIP ON THOSE INSTITUTIONS. WE ARE CURRENTLY ANALYZING THE COMMENTS ALREADY RECEIVED AND WELCOME ANY ADDITIONAL SUGGESTIONS WHICH THIS SUBCOMMITTEE MIGHT MAKE.

CONGRESS HAS AUTHORIZED THE SECRETARY TO MAKE ADJUSTMENTS IN THE PPS RATES FOR HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW-INCOME OR MEDICARE PATIENTS, IF DATA INDICATE THAT THERE ARE LEGITIMATELY HIGHER COSTS ASSOCIATED WITH SUCH PATIENTS. WE HAVE BEEN STUDYING THIS ISSUE BUT, UNFORTUNATELY, HAVE NOT

BEEN ABLE TO DEVELOP A MEANS TO ACCURATELY IDENTIFY "DISPROPORTIONATE SHARE" HOSPITALS OR TO MEASURE ANY HIGHER COSTS ASSOCIATED WITH SUCH PATIENTS. OUR PRELIMINARY ANALYSIS, USING THE ONLY IMMEDIATELY AVAILABLE DATA BASED ON A 2-WEEK SURVEY OF HOSPITALS CONDUCTED BY THE OFFICE OF CIVIL RIGHTS IN 1981, INDICATED THAT THE DATA ARE HIGHLY QUESTIONABLE. FOR EXAMPLE, SOME HOSPITALS KNOWN TO HAVE HIGH MEDICAID PATIENT LOADS SHOWED UP IN THE SURVEY AS HAVING NONE.

WE ARE CURRENTLY SEEKING OTHER SOURCES OF DATA AND, AS ANOTHER ALTERNATIVE, WE ARE EXPLORING THE USE OF ZIP-CODES AS A PROXY FOR IDENTIFYING PATIENTS WHO LIVE IN LOW-INCOME AREAS. WE HAVE PLACED A HIGH PRIORITY ON THESE PROJECTS AND WILL REPORT THE RESULTS TO CONGRESS AS SOON AS THEY ARE AVAILABLE.

IN THE LONG RUN, THE PROBLEMS OF DISPROPORTIONATE SHARE HOSPITALS MAY BE RESOLVED PENDING THE OUTCOME OF OUR STUDIES ON SEVERITY OF ILLNESS AND THE INCLUSION OF SUCH A VARIABLE IN PPS. RESEARCH ON THIS ISSUE IS

CURRENTLY UNDERWAY AND PRELIMINARY FINDINGS SHOULD BE AVAILABLE FOR INCLUSION IN THE 1985 ANNUAL REPORT AS REQUIRED BY CONGRESS.

WE ARE CURRENTLY REVIEWING EXISTING SYSTEMS WHICH MIGHT BE USED TO PREDICT THE RESOURCES NEEDED FOR CARE DURING A BENEFICIARY'S HOSPITAL STAY. THESE SYSTEMS INCLUDE: DISEASE STAGING WHICH TRACKS PROGRESSION OF DISEASE WITHIN THE PARTICULAR CONDITION; PATIENT MANAGEMENT CATEGORIES WHICH CLASSIFY PATIENTS WITHIN SPECIFIC DISEASE GROUPS ACCORDING TO MEDICAL MANAGEMENT NEEDS; ACUTE PHYSIOLOGY AND CHRONIC HEALTH EVALUATION WHICH USED PHYSIOLOGIC VARIABLES AND CHRONIC HEALTH CONDITIONS; MEDICAL ILLNESS SEVERITY GROUPINGS WHICH USE CLINICAL AND X-RAY FINDINGS AS WELL AS PHYSIOLOGICAL VARIABLES BOTH AT ADMISSION AND AT A SPECIFIED TIME DURING A STAY; AND A SEVERITY OF ILLNESS INDEX WHICH EXAMINES MEDICAL RECORDS AFTER DISCHARGE TO DETERMINE WHICH OF FOUR SEVERITY LEVELS WAS INVOLVED.

WE VIEW THE SEVERITY ISSUE AS A LONG TERM PROJECT DIVIDED INTO THREE PHASES. FIRST, WE ARE DEVELOPING A COMPREHENSIVE DATA BASE TO PERMIT COMPARISONS AND POSSIBLY IMPROVE THE COMPUTATION OF WEIGHTS FOR THE VARIOUS DIAGNOSIS-RELATED GROUPS (DRGS). SECOND, WE WILL STUDY WHETHER THERE ARE HOSPITALS WHOSE PATIENTS

CONSISTENTLY HAVE ABOVE AVERAGE TREATMENT REQUIREMENTS AND HOW TO UPDATE BOTH THE DRG CLASSIFICATION SYSTEM AND PRICING TO REFLECT CHANGES IN PRACTICE AND TECHNOLOGY. FINALLY, WE WILL DEVELOP AND TEST CASE-MIX SYSTEMS WHICH MEASURE THE VARIABLES WHICH HAVE BEEN FOUND SIGNIFICANT IN OUR EARLIER STUDIES.

ANOTHER ISSUE WHICH THE DEPARTMENT HAS BEEN ADDRESSING IS THE APPROPRIATE TREATMENT OF CAPITAL COSTS UNDER PPS. CURRENTLY, THESE COSTS ARE REIMBURSED SEPARATELY, OUTSIDE THE PPS PAYMENT RATE. AS YOU KNOW, THE DEPARTMENT IS PREPARING THE CONGRESSIONALLY-MANDATED REPORT CONCERNING HOW CAPITAL REIMBURSEMENT MIGHT BE INCLUDED IN THE PROSPECTIVE PAYMENT RATE.

THERE HAVE BEEN SUGGESTIONS THAT ONE METHOD TO SAVE COSTS WOULD BE TO REDUCE OR ELIMINATE THE RETURN ON EQUITY CAPITAL NOW PROVIDED TO PROPRIETARY HOSPITALS AS PART OF THEIR CAPITAL COSTS. PROPONENTS OF THIS CHANGE SUGGEST THAT THE PROSPECTIVE PAYMENT RATE PROVIDES SUFFICIENT OPPORTUNITY TO ACHIEVE A PROFIT. THE CAPITAL REIMBURSEMENT STUDY WHICH WE WILL BE SUBMITTING SOON IS REQUIRED TO ADDRESS THE APPROPRIATE TREATMENT OF RETURN ON EQUITY CAPITAL AS PART OF THE PROSPECTIVE PAYMENT RATE. WE, THEREFORE, BELIEVE IT WOULD BE

INAPPROPRIATE TO MAKE PIECEMEAL RECOMMENDATIONS PRIOR TO DEVELOPING A COMPREHENSIVE STRATEGY FOR CAPITAL REIMBURSEMENT.

MR. CHAIRMAN, WE BELIEVE THAT MEDICARE'S PROSPECTIVE PAYMENT SYSTEM HAS MADE REAL STRIDES IN ENCOURAGING GREATER EFFICIENCY WITHIN THE HEALTH CARE INDUSTRY WITHOUT SACRIFICING ACCESS TO OR QUALITY OF CARE FOR BENEFICIARIES. WE DO NOT CLAIM THAT THE SYSTEM IS PERFECT. ADJUSTMENTS AND REFINEMENTS WILL ALWAYS BE NEEDED TO KEEP PACE WITH TECHNOLOGICAL AND OTHER CHANGES IN THE HEALTH CARE SYSTEM. WE ARE ATTEMPTING TO ADDRESS THE ISSUES IN A COMPREHENSIVE AND SYSTEMATIC MANNER SO THAT ANY CHANGES THAT MAY BE REQUIRED WILL CAUSE MINIMAL DISRUPTION TO HOSPITALS.

THIS CONCLUDES MY PREPARED REMARKS. I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Chairman **Stark**. Dr. Davis, did OMB review your testimony today.

Ms. **Davis**. I believe that is the usual process.

Chairman **Stark**. Did they eliminate—were there changes?

Ms. **Davis**. Well, there are always editorial comments. Everybody thinks they are an English major.

Chairman **Stark**. If the hospitals were given their normal update under the PPS market basket plus a quarter, what would the rate be?

Ms. **Davis**. About 5.15.

Chairman **Stark**. All right. In your opinion should Medicare continue to pay a return on equity for proprietary hospitals?

Ms. **Davis**. I don't think we are prepared to make a final recommendation on that. It is part of the overall capital study.

Chairman **Stark**. Do you have a formula, a procedure under which you would make a recommendation? I mean what information do you need to make that?

Ms. **Davis**. I believe the capital study itself has been looking at a variety of issues including whether or not we continue with the return on equity. Depending upon what system is advanced, that——

Chairman **Stark**. What are the alternatives that you are looking at?

Ms. **Davis**. Part of the problem is that the study is not being done within HCFA, but within another part of the Department, so I am not as familiar with it as if it were one of our studies, Mr. Chairman.

Chairman **Stark**. Who is doing the study?

Ms. **Davis**. It is being done by planning and evaluation.

Chairman **Stark**. Who heads planning and evaluation?

Ms. **Davis**. I believe that is Mr. Bob Helms.

Chairman **Stark**. Bob?

Ms. **Davis**. Mr. Bob Helms.

Chairman **Stark**. H-e-l-m-s?

Ms. **Davis**. Yes.

Chairman **Stark**. Is he available to testify?

Ms. **Davis**. I believe he has testified in the past, yes.

Chairman **Stark**. We have been led to believe that you have data within the Department now that demonstrates that hospitals serving disproportionate share of low income patients have higher medical costs per case. Does that data exist, may I ask either of your research people?

Ms. **Davis**. We have some data, but again, it was predicated on a study done in 1981 through the Office of Civil Rights. Because the data was so flawed——

Chairman **Stark**. Can we have that data and look at it?

Ms. **Davis**. I believe it is premature for us to release that because it was so flawed. When we looked at that particular data—I will ask the researchers if they would like to comment—many of the hospitals involved in just a small sample were seriously flawed in relationship to new data we now have.

We estimate within 6 weeks time to have the new data identified and reviewed to be able to rerun the whole system using the new data. So that I would prefer to have the new data in the study in about a month's time.

Chairman **Stark**. So you are suggesting that by the end of June we will have the report on disproportionate share?

Ms. **Davis**. By the end of June I will certainly have the report done.

Chairman **Stark**. Let me approach this a different way.

I think there is strong sentiment in this committee, that is just my sense of the committee, to provide additional payments for disproportionate share hospitals. If the committee took up the legislation to do this, would the administration oppose such legislation.

Ms. **Davis**. I don't think, Mr. Chairman, I can speak for the administration on that.

Chairman **Stark**. Would HCFA oppose it?

Ms. **Davis**. Again, until I finish the study it would be presumptuous of me to make a recommendation.

Chairman **Stark**. OK.

Ms. **Davis**. We have to wait and find out what the results of the study indicate.

Chairman **Stark**. If you thought, and if in the wisdom of your court it seemed, that the committee would approve legislation providing adjustments for disproportionate hospitals, wouldn't it make sense for your staff and ours to share whatever information does exist so we develop a more rational policy? If you thought the legislation was on a fast track, wouldn't it be in the interest for the administration to work with us?

Ms. **Davis**. We are always interested in working with the staff on this. I believe we have shared with the staff our concerns on how flawed the date is. I know when they sent forward their recommendation they didn't have a final solution on this either. Both groups have been back and forth in touch with each other trying to look at a different data base.

As you understand, we don't normally keep that kind of data. It's been very difficult for us to identify correctly the list of hospitals. Once we do that, we would be able to determine whether there needs to be any kind of adjustment.

I think we want the system as a total to be fair. If it proved there should be an adjustment, then obviously we would want to assure fairness in the system by making a recommendation.

But until we have followed all our procedures, and gotten the data, I can't make that judgment because it would be inappropriate based on the flawed data.

Chairman **Stark**. You are not sure right now, your professional training and your instinct and suspicions don't lead you to feel conclusively that what we tend to refer to as disproportionate share hospitals have higher costs and are entitled to higher reimbursement. That isn't a given in your professional judgment?

Ms. **Davis**. It is not a given in my professional judgment that we know what the reasons might be for those kinds of variations.

Chairman **Stark**. So just variations by themselves, the statistical correlation wouldn't be sufficient for you to give them extra money?

Ms. **Davis**. I would want a little bit more assurance that it's not simply due to inefficiencies or something of that nature. None of us would want to reward that. If indeed we can track it to a standard of care issue that is involved then I think that it is appropriate to recognize that.

Chairman **STARK**. Mr. Gradison?

Mr. **GRADISON**. Thank you, Mr. Chairman.

Ms. Davis, we are moving, however haltingly, toward a prospective system for hospitals. We are talking about a prospective system, of some type, for capital. As we do this there has been explosive growth in the reimbursement and services provided for outpatients.

Some of this, perhaps most of this, makes good sense in terms of what is appropriate for the patient and appropiate for the public purchasers. However, looking further down the road would you envision that there should be some fundamental change in the present cost-based reimbursement system for outpatient services under Medicare?

Ms. **DAVIS**. Yes; Mr. Gradison, I intend to work toward the development of a prospective system for that. We do have collection of data ongoing at this moment to eventually bring that about, either integrated into the system or as a separate prospective payment.

Mr. **GRADISON**. Do you have even a rough time line as to how long it would take to collect the data? I appreciate this isn't going to be done in weeks or months, but when roughly do you think would be a reasonable target for us to expect some useful data on the subject?

Ms. **DAVIS**. I think we have been thinking probably a couple of years. Our first rough material will be in in about a year's time.

Mr. **GRADISON**. Thank you.

Thank you, Mr. Chairman.

Chairman **STARK**. Mr. Rangel.

Mr. **RANGEL**. Thank you, Mr. Chairman.

I probably didn't understand your testimony, Dr. Davis. I assume that you weren't saying that you didn't know from your own personal experiences that certain hospitals that service the poor did not have higher expenses?

Ms. **DAVIS**. Well, as a practicing nurse that has worked in hospitals where there have been such patients, I am aware those hospitals have certain needs but I can't speak specifically——

Mr. **RANGEL**. I know you can't. That is where I misunderstood you. You are saying as a nurse it was your general experience before you joined the administration that poor folks generally had higher costs because of the treatments that were given them?

Ms. **DAVIS**. No, sir, I am simply saying that I am aware of the fact that hospitals that treated a large number of the poor certainly had their own set of problems.

But as to whether those problems are the result of something that is inherent in that it costs more to treat those patients, or whether it is simply due to inefficiencies in the system itself, I don't know. That is what we are waiting for data on.

Mr. **RANGEL**. I see. So you would need a report to find out if a hospital that took care of just Medicare and Medicaid people and had no choice but to accept anyone that came there, as opposed to another hospital that had private sector insurance and you just took a look at both of them, you would not be able to make a professional judgment as to which ones would need more help, more professional assistance or the status of their health generally when they were admitted to the hospital?

Ms. **Davis.** I don't think it is appropriate for me to make just a hunch judgment on these factors.

Mr. **Rangel.** As a nurse.

Ms. **Davis.** Even as a nurse, I think that being a nurse helps me in my job, but I would admit that I ought not use that——

Mr. **Rangel.** My sister is a nurse. She claims there is a heck of a difference working in a public hospital and working in a private hospital. Would you think that is so? In terms of the amount of work that older, sicker patients require?

Ms. **Davis.** I can't make a judgment on that. I think it varies in relationship to the staffing pattern——

Mr. **Rangel.** If you can't make a judgment on any of those things, and this committee thinks it is very important to provide some type of additional payments for disproportionate share hospitals, and you have no independent judgment and nobody on your staff has any independent judgment, why is it that you can't get professional help in order to get a judgment so that we can move on this?

Ms. **Davis.** Mr. Rangel, we are trying very hard to get this report in——

Mr. **Rangel.** How long has it been, Dr. Davis, since we have asked for this information? And what are we asking for? Hospitals that patients are dumped on them. The public hospital system. You know that some hospitals don't take a lot of these people in, as a matter of fact. So when you find a hospital taking the sickest of the sick, the poorest of the poor, you don't find it necessary to find out whether or not they have additional expenses or whether they are just inefficient?

Ms. **Davis.** Yes, sir; we have been involved in looking at this for the last few years since we began the prospective payment system. Our initial look indicated there was not any difference.

Congress asked us to continue to study it. We have continued to study it. This last year in the Deficit Reduction Act, one of the 20 reports the Congress required of us, asked us to identify the disproportionate share hospitals. We have been trying to do just that.

I have indicated exactly where we are on that and the fact we do anticipate having that information in about the next month's time. But again, I think any time you have a system of $44 billion, it would be inappropriate to make judgments based upon somebody's hunches. We need to have the statistical——

Mr. **Rangel.** We are not talking about hunches. That is such a rough word you are using, Doctor. We asked in the Tax Equity and Reform Act of 1982 that you not give us your hunch but give us a professional opinion.

There were some of us, I was included in that number, that were under the impression that a lot of people were not getting proper medical care because the hospitals were overcrowded with poor folks. So that you know, when I was chairman of this committee, I had people testify that ambulance drivers would determine where the patient would go based on the neighborhood they picked up the patient.

We have had private hospitals claim that they had wallet biopsies to determine whether they were going to bring in the patients. We had public hospitals say they have to take anybody.

And that it was more expensive because the poor folks waited until they had to be carried away, unlike people that can take elective surgery. So all of the facts 3 years ago appeared to be going in the direction that the sicker you are, the more care it would take, the more doctors you would need, the more nurses you would need.

Even if that information is wrong, wouldn't you want to make certain that we would know that the doctors are just dumber and the nurses are just more inefficient in the hospitals that serve the poor, rather than to have it the other way around, that we are giving less care to those who need it the most?

Why would it take 3 or 4 years to find that out? I am not asking for a hunch.

Ms. DAVIS. Well, as I indicated, Mr. Rangel, we did do one study. We worked with the public hospitals in that study. When we looked at that study initially it did not indicate to us that there was any difference in the level of illness that related to the amount of care that was being given for Medicare patients.

Since then we have gone back and begun to look at other data sources too. We are at this point trying to merge several of those and hope to have that report.

Mr. RANGEL. When?

Ms. DAVIS. Well, I indicated that our timeframe to complete the identification of the disproportionate share data and to look at the runs that were a result of that would probably be about 4 to 6 weeks from now.

Mr. RANGEL. You have no idea what the results would be?

Ms. DAVIS. Well, no, sir, I don't. We haven't completed the data sorting yet.

Mr. RANGEL. I am sorry, I just thought maybe they might share with you if there was an emergency situation where the hospitals that serve the poor would need additional assistance while we are going through the budget.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub.

Mr. DAUB. Mr. Chairman, if I might spend a little time on the subject of the age index, and have a little time with other witnesses, because it is one that I find my constituents are most interested in.

Chairman STARK. Proceed.

Mr. DAUB. I want to say that I think we are on the right track with Medicare prospective payment systems. Dr. Davis, we are glad you are here because I want to talk to you about the issue of the area wage index. I think hospitals are responding to PPS by becoming more efficient—hospital admissions are declining and the financial viability of our hospital industry is continuing to improve.

It is important, however, that Congress, and I think all of my colleagues here before have indicated that, particularly this Subcommittee on Health, continue to examine changes that will have to occur and refinements and improvements that will have to occur in the prospective payment system. So, today, Mr. Chairman, I am urging our subcommittee to pursue legislative action, requiring the swift initiation of a rulemaking process and implementation of the revised Medicare wage indices submitted in HHS's March 29 report to the Congress. The Medicare wage index adjusts to account for differences in area wages.

The intent of Congress was to treat all hospitals fairly. Instead, the current index penalizes many hospitals. The index does not adjust for those hospitals that traditionally employ a large number of part-time employees, a practice that proves successful in controlling health care costs. For nearly 2 years many Members have worked to devise a more fair wage index.

I would like the record to show, Mr. Chairman, the letter written to you by our colleague, Berkley Bedell, dated May 7.

Chairman STARK. Without objection.

Mr. DAUB. I would also like the record to include a number of letters from Members addressed to various folks from the President of our country to the Secretary of HHS—letters initiated in large measure by Members like Mr. Stenholm from Texas and Mr. Tauke of Iowa, expressing a very bipartisan consensus. I would also like the record to include the pages from special orders taken by Members on this issue.

Chairman STARK. Without objection, that will be part of the record.

[The statement of Mr. Daub and the attached letters follow:]

STATEMENT OF HON. HAL DAUB, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Chairman, we are on the right track with the Medicare prospective payment system. Hospitals are responding by becoming more cost efficient. While hospital admissions are declining, the financial viability of the hospital industry is continuing to improve.

It is important, however, that the Congress, and, specifically, our Subcommittee on Health continues to examine changes which will further refine and improve the prospective payment system.

Today, Mr. Chairman, I am urging the Subcommittee on Health to pursue legislative action requiring the swift initiation of a rulemaking process and the implementation of the revised Medicare wage indices, submitted in HHS's March 29 report to Congress.

The Medicare area wage index adjusts the Federal reimbursement rate to account for differences in area wages. The intent of the Congress was to treat all hospitals fairly. But, instead, the current index penalizes many hospitals. The index does not adjust for those hospitals that traditionally employ a number of part-time employees—a practice that proves successful in controlling health care costs.

Many Members have worked to devise a more fair wage index for nearly 2 years. Congress recognized the shortcomings of the current index and required that the Secretary of HHS report revised indices within 30 days of the enactment of the Deficit Reduction Act which passed last summer.

Unfortunately, the compilation of the hospital data needed to devise a new wage index was more complicated than originally expected and a final report was not received by the Congress until March of this year.

Since a recommendation from the Department has not been received, it is now the responsibility of the Congress to move ahead with this long-awaited report. I have drafted legislative language that will put the revised gross index into place on October 1, 1985. The new index should be published as part of the proposed notice of payment rules in June, becoming effective on October 1.

The Deficit Reduction Act also required that those hospitals that had been underpaid would receive retroactive compensation. At the same time, the Department was required to recoup overpayments from those hospitals that had been overpaid due to overstated wage indexes. When the Deficit Reduction Act passed, Congress did not foresee the several month delay in reporting the revised indices. It was impossible to predict the magnitude of the recoupments we now face. For this reason, although the hospitals in my State of Nebraska stand to gain millions of dollars under the current retroactive provision in the law, I would support legislative language to remove the retroactive provision as long as the revised index is completely implemented on October 1, 1985.

The importance of the revised index implemented at the beginning of fiscal year 1986 is a matter of fairness and equity. Numerous hospital associations, both the so-called "winners" as well as the so-called "losers" under the new index, support the implementation of a revised index.

Under the prospective payment system, the hospitals have made enormous progress in controlling rising health care costs. In order to encourage these hospitals to "keep faith" in the system, it is incumbent upon the Congress to demonstrate the willingness to be responsive to changes and to correct obvious inequities.

I encourage my colleagues to join me in supporting legislative action to implement the revised wage index on October 1.

Congress of the United States
Washington, D.C. 20515

September 27, 1984

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madame Secretary:

As Representatives of districts within the West North Central Region, we are gravely concerned about the threat to rural hospitals and the rural health care system overall posed by clearcut inequities in the prospective payment system's treatment of labor and non-labor standardized costs for rural hospitals We are deeply frustrated by the failure to address and remedy these inequities in the Fiscal Year 1985 final prospective payment regulations, and we urge you to take action immediately to correct these inequities. We realize that rural versus urban reimbursement differentials are "under study." But our rural hospitals cannot wait for studies and possible relief in the future. It will come too late, if it comes at all, to save them. It will come too late, if it comes at all, to ensure that we maintain and enhance the improvements we have made in rural health care over the past decades.

We understand the rationale for some differences in the reimbursement rates for labor costs for rural versus urban hospitals. We cannnot understand, howeve the enormous gap in the West North Central Region, where urban hospitals receive 25 percent more for standardized labor costs than do rural hospitals. This differential is particularly devastating for rural hospitals located near urban areas and competing in urban labor markets for staff.

The 54 percent differential for standardized non-labor costs for rural versus urban hospitals in our region is frankly incomprehensible. It stands to reason that for some non-labor items, rural hospitals actually incur greater costs due to lower volume purchasing and usage.

The 25 percent and 54 percent differentials our rural hospitals struggle under are greater than the percentages of differentials in any other region and for the national rates.

Something is clearly and terribly wrong here. Our rural health care system is imperiled. For as our rural hospitals close their doors, it will become increasingly difficult to attract and hold physicians in rural areas, leaving our rural constituents without the high-quality, community-based health care service that have taken so long to build.

It is contrary to the intent of the prospective payment system to close the doors of our rural hospitals, which have traditionally provided high-quality care at costs lower than urban facilities, and force rural residents to seek care in more expensive urban facilities. The inequitable treatment of rural hospitals under the current prospective payment system will drive up, rather than contain, hospital care costs.

For the sake of our rural residents, rural hospitals, and rural health care system, and in the interest of containing hospital care costs, the inequities in the prospective payment system's treatment of rural hospitals must be immediately addressed and remedied.

Thank you for your consideration of this appeal.

Sincerely,

IOWA

Berkley Bedell
Berkley Bedell, M.C.

Cooper Evans
Cooper Evans, M.C.

Tom Harkin
Tom Harkin, M.C.

Jim Leach
Jim Leach, M.C.

Neal Smith, M.C.

Tom Tauke, M.C.

KANSAS

Dan Glickman
Dan Glickman, M.C.

Pat Roberts
Pat Roberts, M.C.

Jim Slattery
James Slattery, M.C.

Whittaker
Bob Whittaker, M.C.

MINNESOTA

Jim Oberstar
Jim Oberstar, M.C.

Tim Penny
Timothy Penny, M.C.

Arlan Stangeland
Arlan Stangeland, M.C.

Vin Weber, M.C.

MISSOURI

Tom Coleman
Tom Coleman, M.C.

Bill Emerson
Bill Emerson, M.C.

Ike Skelton
Ike Skelton, M.C.

Gene Taylor
Gene Taylor, M.C.

Harold L Volkmer
Harold Volkmer, M.C.

NEBRASKA

Doug Bereuter
Doug Bereuter, M.C.

Hal Daub
Hal Daub, M.C.

Virginia Smith
Virginia Smith, M.C.

SOUTH DAKOTA

Thomas A. Daschle
Tom Daschle, M.C.

Congress of the United States
House of Representatives
Washington, D.C. 20515

March 28, 1985

The Honorable Ronald W. Reagan
The President
The White House
Washington, D. C. 20500

Dear Mr. President:

We are writing concerning the threat posed to the survival of our rural hospitals and the quality of rural health care by the inequities that exist in the Medicare prospective payment system.

Specifically, we are writing to call your attention to the flagrant abuse of power by the Secretary of the Department of Health and Human Services and to ask your assistance in obtaining her immediate cooperation and compliance with congressional intent and statutory mandate.

Not only are our hospitals struggling in the midst of the agricultural credit crisis, but they are being short-changed by Medicare. At a time when every penny counts, they are being substantially underpaid for the services they provide to Medicare patients because of the adjustment made in the prospective payment reimbursement formula for area wage differences.

This problem should not be unfamiliar to you; several of us have called it to your attention in previous letters. All of us of have repeatedly written and spoken to HHS Secretary Heckler, HCFA Administrator Dr. Davis, and countless department officials.

Since the implementation of the prospective payment system in October 1983, we have tried to work with the Secretary to have the problem corrected administratively. We were promised this could and would be done. When it appeared obvious that this promise would not be kept, Congress addressed the issue in the Deficit Reduction Act, signed into law by you in July 1984. In that legislation, we mandated that the Secretary revise the area wage indices and report back to Congress within thirty days. That deadline was not met, and since then, we have had nothing but more broken promises, missed deadlines, and lame excuses.

If we sound upset and frustrated, be assured that we are. We in Congress have been patient, we have been accomodating, and we have been cooperative. We have no such adjectives to describe the actions of the Secretary in regard to this issue.

HHS has put the blame on Congress, on the hospitals, on unreliable data. We've listened to excuse after excuse about the need to verify data. Well, that data has been checked, double-checked, and checked again. Now in a letter this week, we are supposed to buy the argument that separate rule-making to implement the revised indexes cannot be done; we have to wait until the annual rulemaking for Medicare, which means no revised wage indices, no help for our hospitals, and no equity in the system until at least October 1.

We urge you to do everything in your power to resolve this unfortunate and needless situation. We respectfully request the release of the report on the revised wage indices and that the rule-making process be immediately put in progress in order that rural hospitals can begin to receive fair treatment from Medicare and adequate reimbursements. Thank you.

Sincerely,

IKE SKELTON, M.C.

Pat Roberts
PAT ROBERTS, M.C.

Charlie Stenholm
CHARLES STENHOLM, M.C.

Sid Morrison
SID MORRISON, M.C.

Jim Lightfoot
JIM LIGHTFOOT, M.C.

Mickey EDWARDS
MICKEY EDWARDS, M.C.

Arlan Stangeland
ARLAN STANGELAND, M.C.

Virginia Smith
VIRGINIA SMITH, M.C.

Dan Glickman
DAN GLICKMAN, M.C.

Bill Emerson
BILL EMERSON, M.C.

Tom Loeffler
TOM LOEFFLER, M.C.

Berk Bedell
BERKLEY BEDELL, M.C.

Dan Daniel
DAN DANIEL, M.C.

Hank Brown
HANK BROWN, M.C.

Tom Tauke

TOM TAUKE, M.C.

Neal Smith

NEAL SMITH, M.C.

Jamie Whitten

JAMIE WHITTEN, M.C.

J- Leach

JIM LEACH, M.C.

Doug Bereuter

DOUG BEREUTER, M.C.

Hal Rogers

HAL ROGERS, M.C.

Joe Skeen

JOE SKEEN, M.C.

[From the Congressional Record, Mar. 7, 1985]

RURAL HOSPITALS REIMBURSED UNFAIRLY FOR CARE TO MEDICARE RECIPIENTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Iowa [Mr. Tauke] is recognized for 60 minutes.

Mr. TAUKE. Mr. Speaker, Members of the House, I have taken this special order today to address a problem which is not unknown to the Members of this body; in fact last year we spent considerable time talking about it. I think that most of the Members of this body, along with the Member from Iowa, believed that we had solved the problem.

Indeed, I am here today to tell you, as a number of my colleagues will tell you, that we did not solve the problem. What is the problem of which I speak? It is the problem of reimbursing rural hospitals in this Nation fairly for the services they provide to Medicare recipients.

How well or how poorly a hospital fares under the new Medicare Prospective Payment System should depend upon its ability to offer needed, high quality, cost-effective care.

But under the prospective payment system as it is now structured, a hospital's reimbursement depends not upon how well it provides services, but depends instead on the location of the hospital. And hospitals that are located in rural areas received substantially less than those located in urban areas.

The inequities in the Medicare prospective payment formula are threatening to close the doors of many rural hospitals, leaving rural Medicare beneficiaries without access to community-based hospital services and imperiling the availability and quality of rural health care services generally. A strong rural hosptial system is essential to attracting physicians, nurses and other health care professionals to rural areas and to retaining them. Rural hospitals serve as bases and resource centers for other health care services, such as home health care, respite care, hospice care, and adult day care for the chronically ill elderly.

Many rural hospitals provide skilled nursing beds, and many are now converting underutilized wings to longterm care units. Rural hospitals have traditionally provided lower cost care than urban hospitals. This very fact that rural hospitals have been efficient and low-cost motivated the creation of the urban-rural differentials in the current reimbursement system, those differentials which today, ironically, are threatening the survival of our most cost-efficient health care providers—namely, rural hospitals.

We have put in place a system which, if unaltered, will shut down the most cost-effective providers and drive rural Medicare beneficiaries into costly urban hospitals.

Rural hospitals in the Midwest, the region which I and others represent, are particularly hard hit. In the West North Central region, which includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota, the standardized labor reimbursement is 25 percent higher—25 percent higher—for urban areas than for rural hospitals. These differentials are greater than those of any other region of the country and greater than the national differentials.

Let me repeat: The standardized labor reimbursement is 25 percent higher for urban than for rural hospitals. Furthermore, the standardized nonlabor reimbursement is 54 percent higher for urban than for rural hospitals in our region. It just does not make sense.

Several examples provided by rural Iowa hospitals of the cumulative impact of these differentials, coupled with the application of an area wage index further reducing reimbursement for labor costs, graphically illustrate the size of the differentials and the reason that rural hospitals in the Midwest are imperiled under the current system.

The Stewart Memorial Community Hospital in Lake City, IA, for example, looked at the reimbursements received for seven frequently occurring DRG's by hospitals in the two metropolitan statistical areas between which that facility is located and compared them with the reimbursement for that hospital in Lake City. The differences are all over 100 percent. So we have one community in between two larger urban areas, and the hospitals in the larger urban areas get over 100 percent more for the services that are provided under Medicare than the hospital in the central community.

The Mary Greeley Medical Center, a rural hospital in Ames, IA, a city of some 30,000, located only 35 miles from Des Moines, reports that a hospital in Des Moines, just 35 miles away, receives 61.7 percent more per DRG. Mary Greeley Medical Center, for example, is reimbursed $4,524.41 for DRG 209, which is major joint procedure. A Des Moines hospital receives $7.314.57 for the same DRG. So one hospital receives $4,524; another hospital 30 miles away receives $7,314.

Now what is the reason for this differential? Primarily, the reason is theoretically that the rural hospital pays lower wage rates, but that is not necessarily the case. While rural wage rates tend to be lower in the rural areas than they are in the urban areas, they are not 25 percent lower. Moreover, the 54-percent nonlabor differential defies comprehension when one considers, first of all, that rural hospitals are more limited than urban hospitals in their ability to hold down supply costs because urban hospitals can buy in bulk.

Second, the range of competing suppliers likely to be available to urban hospitals is not likely to be available to rural hospitals. Transportation costs are added to the cost for rural hospitals, a transportation cost that urban hospitals often do not have to pay. Utilities cost the same or more in rural areas, once again because of lower utilization rates.

So how in the world do you come up with a 54-percent differential in the nonlabor component between urban and rural areas? That, too, does not make sense.

The Health Care Financing Administration argues that these differentials must reflect reality because they say the labor and nonlabor standardized components of the prospective payment system were developed by averaging reported hospital costs in each region. If that is the case, we have put in place a system which is rewarding institutions which have traditionally shown higher costs and penalizing those which have shown lower costs.

Rural hospitals located near urban areas and competing for staff with hospitals in urban areas are especially disadvantaged by the rural-urban differentials. St. Joseph Mercy Hospital and Jane Lamb Health Center are located in Clinton, IA a city in my congressional district with a population of 32,000 but lying within what is known as a rural area under this program. These hospitals must compete with staff for hospitals in the Davenport-Rock Island MSA 30 miles to the south of Clinton. Samuel French, the senior vice president of St. Joseph Mercy Hospital, compared average wages in Clinton County, the rural area, with the average wages in the two MSA's and with his average wages for a number of hospital-relevant occupations. While St. Joseph Mercy Hospital's wage costs are closely comparable to those in the two MSA's, that hospital receives 33-percent less reimbursement for labor costs than hospitals in those two MSA's only a few miles away—I emphasize, as 33 percent difference.

Marshalltown Area Community Hospital in Marshalltown, IA, a rural area 45 miles form Des Moines, provides yet another example of the wage reimbursement inequity. In 1983 the starting wage for a registered nurse in Des Moines averaged $8.31 an hour, and in Marshalltown, $7.96 an hour, a 4.4 percent difference, not the 25 percent difference concluded in the formula.

Rural areas in the Midwest, moreover, have a high percentage of elderly residents, and rural hospitals therefore have a higher percentage of Medicare admissions than is typical of urban hospital. Medicare patients account for 60 to 70 percent of admissions in many rural hospitals. Therefore, rural hospitals are far more dependent upon Medicare reimbursement than urban hospitals and have far less flexibility to respond to short-falls in Medicare reimbursement.

Now, what can be done to make the prospective payment system one under which a hospital's survival is determined by its ability to provide needed, cost-effective, high-quality services rather than upon where it happens to be located?

Well, of course, the answer, in part, is to change the seriously flawed area wage indices in the current system. They must be revised, and the revised indices must be swiftly implemented.

The current indices were developed from the Bureau of Labor Statistics hospital wage and employment data. Last year Congress recognized how bad that data was, and the resulting serious flaws in the area wage indices and provided correction in the Deficit Reduction Act, enacted in July 1984.

The provisions in that act direct the Secretary of Health and Human Services to develop a revised set of indices, taking into account full-time versus part-time employment patterns, and to report this revision to Congress within 30 days after the enactment of the act.

The Secretary missed that deadline, which was in August of last year, and failed to keep a subsequent commitment made to a group of us from the west north-central region to have a report to Congress by December 31 of last year. She missed the August deadline; she missed the December 31 deadline. Now it is March and we still do not have a report to Congress, a report Congress mandated in the Deficit Reduction Act enacted last July.

Now, it is my understanding, from conversations with Secretary Heckler and Dr. Carolyn Davis of the Health Care Financing Administration, that the delays in the issuance of this report have been caused by difficulties in obtaining hospitals-specific data and by concerns about the accuracy of the data once they were collected. These concerns have led to a series of audits, the last of which was completed in late February. In general, these audits reveal that the data reported by hospitals are accurate. The audit process has corrected the problems of some of the remaining data, and officials with the Department of Health and Human Services have reported to me that they are confident enough of the data at this point to issue a report on the revised area wage indices.

But the report still has not been issued.

Today, we have taken this special order to plead with the Secretary of Health and Human Services to get on with it; to get this report issued. Once the report has been issued, we plead with her to implement the revised wage indices as quickly as possible so at least a portion of this tremendous inequity can be corrected and so that we can begin to reimburse rural hospitals at a rate which will allow them to stay in business.

I note, Mr. Speaker, there are a number of Members here on the floor who want to speak to this issue, and I am delighted to yield to the senior Member of the Iowa delegation, the distinguished gentleman from Iowa.

Mr. SMITH of Iowa. I thank the gentleman for yielding, and I want to point out that at our Appropriations Subcommittee meeting last week, the Secretary was there, and I asked her specifically how soon we could expect this report. We covered the importance of what the gentleman has just said.

In addition to that, I would mention that it is going to be important, not only for those that are not getting enough money, but the ones that are getting too much money, if they have to pay back over a year of overpayments, they are going to be in trouble too. She promised that they would have it within 2 weeks of the time, whatever day that was last week that we held that hearing.

Now, I thank the gentleman for having this special order, but I hope that we can get it within that time because that will be plenty late.

Mr. TAUKE. The gentleman has done a tremendous job in attempting to put pressure on the Department of Health and Human Services to do what it is supposed to do. As you know, the Secretary has made commitments before; we hope this commitment is more reliable than some of those that have been previously made.

As the gentleman knows, once we get the report to Congress, we still have to have regulations then formulated by the Department of Health and Human Services. We have to have those approved by OMB. They have to be published before we can actually get the reimbursement rate changed.

As the gentleman so well pointed out, it is a problem not just for the rural hospitals that are being underreimbursed, but we are also overreimbursing other hospitals, and the longer we go on with this kind of a system, the bigger the shock will be to them when they have to start paying back.

I yield to the gentleman from Iowa.

Mr. SMITH of Iowa. She pointed out, she had the statistics there. There are some that it makes a 30-percent differential, and that is a huge differential to try to make up after it has been overdue for 1 year.

Mr. TAUKE. The gentleman makes an excellent point.

I yield to the gentlewoman from Nebraska [Mrs. Smith].

Mrs. SMITH of Nebraska. I thank the gentleman for yielding to me.

Mr. Speaker, I welcome the opportunity this afternoon to comment on the very harmful inequities that exists for rural hospitals under Medicare's prospective payment system. I also rise today to voice my frustration with the bureaucratic road blocks and footdragging that have prohibited problems from being corrected several months ago.

Before continuing, however, I want to thank my good friend and colleague from Iowa, Mr. Tauke, for reserving time today to bring this issue before the House and to acknowledge all his efforts in the past few months to help us resolve the wage-index problem.

It was 2 years ago this month that we gave final approval to the Social Security rescue bill and at the same time established Medicare prospective payment, making the most significant reform in Medicare since the program's inception. Then as now, I am optimistic that when fully in place—when all the kinks have been worked out—prospective payment will improve the efficiency of the Medicare Program and help to control the growth of Federal health-care costs.

Until the refinement is complete, however, there exists serious inequities in the way the new reimbursement system is being implemented, and these inequities pose a very real threat to the continued delivery of health care in the rural areas of the Nation. No where is this being felt more strongly than in rural Nebraska and throughout our neighboring States, which compose—along with Nebraska—the west north central Medicare region.

Many of our colleagues have not dealt with the intricacies of prospective payment and the reimbursement formula, having not been confronted with this issue since hospitals in their districts have not been short-changed on their Medicare reimbursements. All too many, in fact, have gotten more than their fair share of the program benefits. Even a brief summary of the payment system gets complicated, but the bottom line is that the prospective payment system reimburses hospitals based on where they are located on the assumption that it is downright cheap to be sick in rural America as compared to our big cities. Since I've been in Congress, I've had to explain away this misconception to big city bureaucrats time and time again.

Under prospective payment, Medicare reimburses hospitals for inpatient services based on predetermined rates called diagnosis related groups or DRG's. The DRG reimbursement formula includes both a labor and nonlabor component and each is adjusted to reflect this assumed costs differentials between urban and rural areas.

As my colleagues this afternoon have pointed out, the rural/urban differentials for labor and nonlabor costs are greater in our west north central region than in any other region of the country and greater than the national average. Urban hospitals receive 25 percent more for standardized labor costs and 54 percent more for standardized nonlabor costs than rural hospitals receive.

When the standardized labor component, already lower for our rural hospitals, is further adjusted to reflect differences in area wage rates, rural hospitals lose out again, especially those in my district. When the wage indexes were published in September 1983, rural Nebraska had the lowest in the country.

While there are several areas of concern, the major and overriding problem in the prospective payment system is this adjustment made in the Medicare reimbursement for wage-rate variations.

The adjustment is made by applying certain poorly formulated area wage indexes, which were developed by the Bureau of Labor Statistics. The Bureau's faulty data fail to take into account the efficient and extensive use rural hospitals make of part-time personnel, skewing the indexes against the rural hospital.

Because rural Nebraska hospitals use about 31 percent part-time help, the result is dramatic for rural Nebraska. The average of DRG payment rate is nearly 80 percent less than that for urban Colorado, right next door. It is even 50 percent less than the average DRG payment to urban Nebraska hospitals in Omaha.

Prospective payment is 18 months old. From day one, those responsible for administering Medicare, both HHS officials and HCFA officials, have known—I repeatedly called it to their attention—of the inequity created by the flawed wage index, have acknowledged it, have acknowledged that it could be resolved administratively, and have again and again promised to correct the problem.

But to hedge our bet, we were successful in having Congress address the issue with law. The Deficit Reduction Act of 1984 requires the Secretary of Health and Human Services to report to Congress on a revision of the area wage index within 30 days of enactment.

Since I first called HCFA officials to my office in October 1983, shortly after the final regulations for the program were published, I had promises from HHS Secretary Heckler down through the ranks of the bureaucracy that the congressional mandate would be met and that application of the wage index would be corrected and a revised index incorporated in the revised regulations for fiscal 1985. But the regulations were published in September without changes.

We here this afternoon did not take this lying down. We wrote Secretary Heckler and Mr. Tauke hand-delivered the letter. Again, we were given another promise—a report on the revised wage index would be forthcoming no later than December 31.

For a further assurance, I summoned HFCA Administrator Dr. Davis to my office. Again, the same promise. The agency was committed to issuing its report by December 31 and putting in place as soon as possible the revised indexes.

Well, here it is March 7, 2 months later, and all we have is another promise that the report is forthcoming—maybe just 2 more weeks. We do know—via rumor that is—that the revised indexes, based on new wage data collected from the more than 90 percent of the Nation's hospitals during the past year, prove our case—rural hospitals have been underreimbursed and stand to gain, in some cases, substantially. And we know that the data used to develop the revised indexes has been checked, double-checked, and verified one more time. It is reliable and accurate, and Secretary Heckler has no more excuses to use for delaying the wage index report. It is imperative that she keep her most recent promise and meet the 2-week deadline.

The longer we wait for the wage index to be corrected and the correction to be reflected in reimbursement rates, the more we risk rural hospitals closing up shop. Rural hospitals are struggling to survive after months of underreimbursement. They need the most immediate relief possible. And I urge—no I demand—that Secretary Heckler provide it—we risk too much if she does not.

Few doctors are willing to practice without access to a hospital. As our rural hospitals fold, attracting and holding physicians will grow increasingly difficult. We will see a halt to the progress we have made in recent years in bringing high-quality, community-based health care to rural America.

I thank my colleagues for joining with me today to address this grievous inequity in a Federal program that should and could have been corrected long, long ago.

Thank you.

Mr. TAUKE. I thank the gentlewoman from Nebraska, because she has been one of those people who has, time and again, as you have indicated, attempted to put the pressure on the Department of Health and Human Services and the Secretary in order to ensure that this action is taken.

As the gentlewoman pointed out, we are the policymakers, theoretically, in this Government, and the policymakers have spoken. We have mandated the change in the wage indexes, and that change was mandated to take place last year, and yet it has not taken place. We are outraged and we have every right to be, and I think those we represent are outraged too, that this inequity, which everybody acknowledges exists, is allowed to continue in place.

I thank the gentlewoman for her excellent remarks.

I yield to the gentleman from Kansas.

Mr. ROBERTS. I thank the gentleman for yielding.

Mr. Speaker, I want to thank my colleague from Iowa, Mr. Tauke, for organizing this discussion on what amounts to be a real crucial issue that is facing our rural hospitals. The gentleman has been an outstanding leader in our efforts to correct this very unfair reimbursement formula.

What we are really talking about here in this special order is fairness and the ability of citizens in our rural areas to continue to attain at least adequate and affordable health care. Let us consider the following: Is it fair that our rural hospitals are paid less for actually performing the same service as an urban hospital just because they fall into the Government's rural category? Is it fair that our rural hospitals who were promised that they would be reimbursed by the Government for the cost of treating these Medicare patients have not been reimbursed?

Is it fair that the Government, who has promised all of us it would correct, as the gentleman has pointed out, any inequities found in the system has not made the correction for over an 18-month period. I think all sensible people would agree that these conditions are not fair and should be changed. To date, the Department of Health and Human Services has not seen it this way.

Our small rural hospitals are not asking for any special favors or breaks here; they just simply want a fair shake from their Federal Government. Now the difference between maintaining access to rural health care and widespread rural hospital closures is becoming smaller with every day that passes.

I have over 38 hospitals in my district of 50 beds or less. In Kansas, we are losing nearly $20,000 every day as long as this formula is left unchanged. Now, for some States, I guess you could argue that is not a lot of money; I submit to you that in my State, for a rural hospital it is a lot of money, and over a 4-year period would amount to over $30 million.

So today we underscore the urgency that this situation merits. I would like to just speak to the comments made by my colleague and friend from Iowa, Mr. Smith, and the comments that have been alluded to by my friend from Iowa.

Several months ago, I received the same kind of assurance that he received in committee from the Secretary: "We are going to study this; it is going to be about 2 weeks and we will get back to you." Then came the news that we were going to make sure that this formula was accurate; that we really were not going to spin off more money to rural hospitals than was truly justified, and nobody here wants that.

So we were going to study some 60 hospitals; I think the gentleman will recall that study. So in about 2 weeks, we got back with them again and then it was 144 hospitals. Then that study was concluded and, well, now, wait a minute; we are going to have another 2 weeks because there are maybe two or three more hospitals, and we just need the two or three more to fit in this 144-hospital study.

Then after the two or three are done, and I find out, hopefully, that they are done, we are going to have to assess this. We are going to have to study it a little bit further, and maybe in another 2 weeks, we can get back to you.

So I have called for 2 months, after sending down a special report that we did in my district assessing all of the problems in our rural health care delivery system about every 2 weeks. I know the gentleman has, and I know these other folks have as well.

I do not get to talk to the Secretary. I did not ask to speak to the Secretary. After all, she used to be a Member of this body and she has more important things to do than to answer every congressional call. So I talk to the No. 5 man, or No. 4 man, or No. 4 person, or No. 2 person, depending on my blood pressure and the sound of my voice.

So they come on with,

"Well, now, Congressman, I know, I know. We are going to get back to you. You called before. This is a terrible problem. We are going to study it some more. You do not want us to make the wrong kind of decision."

I would say to my friend and colleague and everybody here, and to the Secretary, and to the 5, 4, 3, 2 man, I am tired of the calls. I am tired of the study. I want some action. If we do not get action, I am going to come down here with 1-minutes every day and start numbering the days that this thing has been promised. It will be another *Pueblo* incident, the sinking of the *Pueblo,* when another Member came down here and said that he was fed up and tired of it.

I am fed up and I am tired of it. This is not an HHS decision anymore. This is an OMB decision. We are getting the runaround. If this continues with this study, OMB never wants to spend the money and we will not get reimbursement. We might get something down the road, but we will never get reimbursed what we are owed down the road.

So the message is clear, if anybody can read these proceedings: that this Member intends to quit calling and start speaking from the House floor for them to fact up to this and keep its promise and move forward on correcting the Medicare formula.

Mr. **Tauke.** I thank the gentleman for his remarks. He certainly deserves the applause he is receiving.

Let me point out something that I am sure the gentleman is aware of and alluded to in his remarks. We are not asking for any additional money. In the course of this change of reimbursement, there will be some reductions to some hospitals and some increases in others, but it will be budget-neutral. But if we do not get this formula change in place pretty soon, what is going to happen is, we will have our most efficient hospitals going out of business, the rural hospitals, and our patients will have to go to the more expensive urban hospitals, and as a result it will cost more money.

So we are not asking the Federal Government to spend more for Medicare. Instead, we are trying to save the Government money by making the reimbursement fair.

Mr. Speaker, I yield to the gentleman from Iowa [Mr. Bedell].

(Mr. Bedell asked and was given permission to revise and extend his remarks.)

Mr. **Bedell.** I thank the gentleman for yielding.

Mr. Speaker, I wish to commend the gentleman for bringing to the attention of this body the serious problem that exists today over Medicare's urban rural area wage indexes.

The current problem began in 1983 when Medicare's new Prospective Payment System established different areas wage rates for the reimbursement of urban and rural hospitals. These area wages indexes were based on the assumption that wages are lower in rural communities as compared with urban areas. However, several important facts were not taken into consideration: First, the fact that rural hospital tend to use higher numbers of part-time staff; second, the fact that rural hospitals must pay competitive wages to attract qualified personnel; third, the fact that rural hospitals tend to have relatively high percentages of Medicare patients; and fourth, the fact that the date obtained from the Bureau of Labor Statistics left a lot to be desired—timeliness and reliability being at the top of the list.

These rates are causing serious financial inequities for rural hospitals in Iowa, and throughout the Nation, and if left unchanged, they threaten to undermine the future effectiveness of the whole DRG system. Congress took the much needed step last year of directing the Secretary of the Department of Health and Human Services to issue a report to Congress on revised area wage indexes.

Until this report is submitted to Congress, new regulations on the area wage indexes cannot be proposed and we are all familiar with the lengthiness of the regulation process. It is imperative that this report be completed immediately. Two deadlines have already been missed. Too much time has already elapsed for many hospitals in my district.

On February 10, the Iowa Des Moines Register listed the Iowa hospitals suffering operating losses in 1983, when DRG's went into effect. I had seven hospitals in my own district and many more who were barely in the black. As Ron Dorris—the administrator of Clarion Community Hospital in my district—states in the article, "the 1983 figures hardly are worthy of note in the face of today's realities." And I wholeheartedly agree with Mr. Dorris when he states later in the article that "the rural health care programs the Government has encouraged in the past now will be irreparably damaged before anything is done to correct problems faced by hospitals such as his."

I believe the time is now to correct these unrealistic reimbursement rates. Hippocrates said, "Healing is a matter of time, but it is also a matter of opportunity." Secretary Heckler has the opportunity and I urge her to issue this report so we can get these changes made.

Mr. Speaker, I want to commend the gentleman for the work he has done on this issue. I would like to approach it from a little different aspect, if I might.

I hope people, first of all, realize the problem we have in our rural areas and the economic problems we face, and then what they are proposing we do is pile on top of that these completely unfair methods of reimbursement for a rural hospital.

Mr. Speaker, in 1983, according to the Des Moines Register, there were seven hospitals in my district that suffered losses in 1983, and let me tell you, 1984 is one awful lot worse than 1983.

I thought we had a society wherein we tried to promote the efficient and make use of the efficient. If HHS is correct, and if it costs a lot less to provide services in rural hospitals than it does in urban hospitals, who is it in the Government who could possibly think that what we should do is put the rural hospitals out of business so that people have to go to the more expensive urban hospitals and the people in rural areas have to spend a lot of money to get those more expensive hospitals.

It seems to me that this is just as crazy as trying to destroy the family farm or just as crazy as saying that we are going to eliminate the Small Business Administration; that we better realize that our job is to promote the efficient, take advantage of those less costly services, and if that is the case, surely somebody ought to realize what a terrible mistake this is, not to promptly correct this inequity.

Mr. TAUKE. The gentleman's remarks are right on target, and I thank the gentleman for his hard work on this issue.

Mr. Speaker, I yield to the gentleman from Nebraska [Mr. Bereuter].

Mr. BEREUTER. I thank the gentleman for yielding, and I commend him for his leadership on this subject.

Mr. Speaker, a few minutes ago you might have had the impression that the gentleman from Kansas was upset, and he has every reason to be upset. I am at least equally upset.

What we have here is the arrogance of the executive branch. This is not a policy question. This is a decision that was made by the elected Representatives of the United States sitting in the Congress, and it is arrogantly being disregarded.

I will be in the well at least once every week we are in session, either in a special order on a 1-minute until a change is brought about that implements what this Congress has decided.

Today I am rising with my colleagues because we have a plight in rural hospitals that is very severe. It is a plight that this Congress has addressed, but it is being sidestepped.

We are in trouble out there. The economic and social fabric of our farm communities is under intolerable stress. Because of the farm crisis, the level of health care in many communities is seriously threatened. Individuals in many families are postponing elective surgery, dropping their health insurance, or lowering their coverage. Obviously this has an additional negative effect on small rural hospitals which are already facing financial hardships because of Medicare underreimbursements. In a State where 60 to 70 percent of the hospital beds are Medicare beds, and that is Nebraska, these underpayments may spell disaster for some hospitals. Action now, however, by the Secretary of Health and Human Services could help us avert hospital closures and correct some of the basic inequities in the labor-wage index that contributed to these underpayments.

As all of us here know, Congress recognized the problem of underpayments in the Deficit Reduction Act that was signed into law last summer. That act contained a requirement that the Secretary of Health and Human Services issue a report to Congress on a revised labor-wage index within 30 days of enactment. The report, however, was not forthcoming; and, in fact, was not forthcoming as subsequently promised by the Department of Health and Human Services by December 31, 1984. We're now promised the report by March 14, 1985. It is crucial that this most recent promise be kept.

It is a source of great frustration to this Member that Health and Human Services assures us that they recognize the unfairness of the current wage index used in the repayment formula, while doing nothing to correct it. It is irritating to hear that Health and Human Services recongizes that the effect of the current reimbursement formula is to penalize smaller hospitals for their efficient practices of hiring only the part-time employees that they need. Why, then, doesn't the Department of Health and Human Services release the revised data? We Members from rural States who have been attempting to correct this serious flaw in the prospective payment system have been patient. We have been understanding. We have been accommodating. Certainly it is our desire to continue to be cooperative. But our constituents are suffering. Secretary Heckler, in the name of fairness, those revised indices must be implemented.

As a former Member of this House of Representatives, and I might say as a former member of the Wednesday Group, I ask you to look at why your Department is not following what Congress tells you to do. It is arbitrary, it is capricious, and it is officious, and it is the kind of conduct that should not be tolerated in this Government.

The Nebraska Hospital Association has told this Member that the corrected wage index would result in an 11-percent increase for my rural Nebraska hospitals. This increase could mean the difference between survival or closure for some small hospitals that are stressed to their financial limits, and I might say beyond their financial limits. It is time to end the months of dissension and overt stalling and fulfill the promises given to this body and to individual Members.

I thank the gentleman for letting me get a few things off my chest, and I hope I do not have to be in the well the next week we are in session, but I will be in the well and I hope you will join me there at that time if it is necessary. We are going to resolve this problem.

Mr. TAUKE. I thank the gentleman for his statement, and I can assure him that I will be in the well, if need be, in order to push this issue.

As the gentleman said, we are basically nice fellows.

Mr. BEREUTER. We are nice fellows.

Mr. TAUKE. We are nice guys, and we are patient, accommodating, and understanding, but there is a limit, and we have reached the limit.

Mr. Speaker, I yield to the gentleman from Texas [Mr. Stenholm].

Mr. STENHOLM. Mr. Speaker, I thank the gentleman from Iowa for yielding and I commend him for his leadership on this issue today. It sounds like it is going to get very crowded in the well with 1-minute speeches very soon, because I will add my voice to those who have spoken before in saying that we have studied this issue long enough.

I appreciate the opportunity to speak today on the subject of the plight of rural hospitals, particularly in relation to the current formulas used for disgnosis related group [DRG] reimbursements.

Those who live in urban, densely populated and well served areas may have difficulty in understanding the significance of a hospital in a rural area. To perhaps add a little perspective, I would like to lead a brief guided tour of the 17th District of Texas, which I have the privilege of representing here in Congress.

The 17th District is composed of 35 counties and 31,906 square miles. In other words, my district is larger than 12 individual States and the District of Columbia. Or, if you wanted to combine land area, Massachusetts, Rhode Island, Connecticut, New Jersey, Delaware, Hawaii, and the District of Columbia all together wouldn't be as large as the 17th District. In that expanse of land, there are 2 counties which have no hospitals at all, while 21 more have only one hospital. I have 30 hospitals in my district which have 50 or fewer beds.

It quickly becomes clear that a large percentage of my constituents live in areas where they must travel quite some distance to receive health care, usually from a small hospital. Whether it be for a routine tonsillectomy, an emergency poisonous snake bite, or a tractor accident, the health and life of many of the residents of the 17th District rest in the hands of the rural hospital. The sparsity of the population and the size of the hospitals may not be typical for the Nation, but that makes those west Texans no less deserving than other Americans of access to quality health care. The only way they're going to continue receiving that care is if the DRG formulas are adjusted to allow the rural hospitals to survive.

I want to say very straightforwardly that I have been a supporter of Medicare reform and I have been pleased with the decrease in the rise of costs that we have already seen since the implementation of the DRG plan. Many of my hospital administrators themselves have expressed their support for this plan which forces them to be frugal financial managers. So, while I don't want to throw the baby out, I do think the temperature of the bath water needs some adjusting.

The rural/urban differentials in the prospective payment system assume that rural wages and other costs are lower than those in urban areas, and therefore, rural hospitals are reimbursed an amount smaller than are their urban counterparts for precisely the same services. The rural administrators in the 17th District report that reimbursements often are 25 to 47 percent less, depending on the treatment category. This, I am convinced, is entirely unfair.

To begin with, most rural hospitals in west Texas must offer their professional staffs at least as much pay as the urban hospitals offer, simply to attract the professionals to those remote, less developed areas. My rural hospitals have an ongoing battle in meeting the 24-hour nursing requirement and finding doctors to staff the hospitals. The problem is not a lack of energetic and creative recruitment efforts, but rather the inherit lack of the benefits of urban life—job opportunities for spouses, cultural and recreational activities, academic resources, et cetera. Frequently, a salary which can compete with or exceed an urban job offering is the largest, and one of the few, incentives a rural hospital can use to attract personnel.

Second, small hospitals are not able to use the economies of scale in purchasing materials that larger hospitals can use. Without the advantages of bulk buying, small hospitals have higher per unit costs.

Third, the rural component for wage costs used by the Health Care Financing Administration was developed from Bureau of Labor Statistics data which do not take into account factors such as part-time versus full-time employment. Since rural hospitals tend to use higher numbers of part-time employees, which in the long run are most costly, the area wage indices are artificially low for rural areas.

Fourth, statistics show that rural areas have a disproportionately high percentage of elderly residents. These elderly folks generally require more health care, and their illness tend to be more serious, requiring a greater length of care. Thus, many of the rural hospitals carry extremely high Medicare patient loads, often ranging from 60 to 80 percent of their entire patient care. Every hospital administrator in the country will attest to the fact that private paying patients are counted on to recoup the money lost on Medicare/Medicaid patients. When 80 percent of the patient load is Medicare patients, there are not enough other patients to help carry the financial burden.

Finally, there is a need to allow time for smaller hospitals to adjust to the new financial diet imposed by prospective, rather than retroactive reimbursement. A progressive hospital board president recently told me about the plans for new programs his hospital expected to implement within 5 years. Many larger hospitals utilize money makers such as weight control, smoke-stoppers, physical fitness, and adult day care programs to make up losses in bed patient costs. Rural hospitals typically have had only bed patients as their source of income, and have not expanded into newer, innovative programs. This board president explained that DRG's have provided the motivation for rural hospitals to start thinking in more businesswise ways, and this is a positive step. But, he warned, creating, fine tuning, and implementing these new operations takes time, and rural hospitals must be given the opportunity to survive in the meantime. In the process of imposing a financial diet, the Government must not push hospitals to the point of starvation and death.

There seems to be little question that the rural/urban formula for Medicare reimbursement needs to be recalculated. Congress recognized the problem and via the Deficit Reduction Act of 1984, required the Secretary of Health and Human Services to issue a report on this issue within 30 days of enactment. Now, more than 6 months later, we still have not seen the report. With rural hospitals struggling and the basic health care of many Americans at risk, we cannot tolerate continued bureaucratic procrastination.

I strongly urge the Secretary to promptly deliver the report that has been ordered, and to continue by further evaluating the Medicare reimbursement formula in order that rural hospitals might be treated more fairly and allowed to meet the health needs of rural America.

Mr. TAUKE. Mr. Speaker, I thank the gentleman. He has made the case very eloquently.

Mr. Speaker, I yield to my colleague the gentleman from Nebraska [Mr. Daub].

Mr. DAUB. Mr. Speaker, I appreciate the gentleman yielding.

Mr. Speaker, I want to rise and add my voice of concern about the delayed report from the Department of Health and Human Services to the Congress on the revised wage indices for reimbursement of hospitals under Medicare.

The wage index, as we have heard from a number of the previous speakers, as a part of the new prospective payment system initiated in 1983, was intended to adjust the Federal reimbursement rate to account for differences in area wages.

The intent of the Congress was to treat all hospitals fairly, but instead this faulty index unjustly, it was discovered, penalizes many hospitals. For example, the current wage index does not adequately adjust for those hospitals which traditionally employ a lot of a part-time employees. This practice, particularly common in Nebraska hospitals, proves to be a cost effective and successful way to control what have been up until now very excessive and spiraling health care costs; yet the current wage index penalizes those hospitals for these applied cost saving methods.

Recognizing the problems that do exist with the current wage index, Congress mandated the Health and Human Services Department to report, as we know now, within 30 days after the enactment of the Deficit Reduction Act of 1984, a revised index. We have yet, obviously, to receive this report.

Now, our hospitals have kept their part of the deal. Since 1983 hospitals across this Nation have initiated cost containment procedures and admissions and lengths of stay have fallen. In the Omaha area that I am privileged to represent, in the past year people collectively spent over 12 percent fewer days as hospital patients. It is past time that we keep our end of the deal and receive for implementation the revised wage index.

Now, I recognize and I realize the difficulties that the HCFA encountered in collecting reliable data upon which to base such a revised index, and quite honestly, I appreciate their efforts and know that some of the slowness in this process resulted from some hospitals not getting their information in so that it could be tabulated.

I also think that my colleague would agree that we do not want another faulty index and have to go through the procedures again of another revision. But we have exceeded this deadline. The deadline we now face is one confronting those hospitals that are being unjustly penalized through inadequate payments due to this first inaccurate wage index.

This unjust reimbursement creates problems as we now know for many of our rural hospitals. I might add many urban hospitals as well, which if not corrected in a more timely manner will threaten the continued operation of many of these institutions, and most seriously threaten the availability of health care services in many areas of our country.

The revised index is important to my State of Nebraska which now ranks dead last among the 50 States on the Medicare wage index reimbursement scale. Nebraska ranks fourth per capita in the number of elderly persons. Dur to this large elderly population Nebraska hospitals serve a disproportional number of Medicare recipients.

We cannot let this process drag on any longer than it already has. The report from HHS must be issued.

I want to say we all agree that the diagnostic related group approach, the prospective payment process we took upon ourselves in the Social Security revisions of May of 1985 are all well and good, and we have appreciated already in this first 18 months the cooperative nature of administrators and professionals in hospitals, and all of us in Government to try to lower the cost of health care.

We are on the right track. I certainly want to, as a former member with my colleague who called this special order of the Health and Long Term Care Subcommittee of the Aging Committee, commend the gentleman from Iowa [Mr. Tauke] for the efforts and for your leadership that you bring to bear upon this very important and critical issue, particularly to rural and farm America. I think it is important.

I was delighted to note that my two colleagues, the gentlewoman from Nebraska, Virginia Smith, and the gentleman from Nebraska, Doug Bereuter, preceded me in this special order, who have worked so hard to try and assist us all in bringing some pressure to bear on the administration to get this matter resolved.

I want the gentleman to know that as a new member of the Health Subcommittee of the Ways and Means Committee, our staff is looking at this very same problem from a legislative point of view. The only difficulty I see now is that if we do get the revised index issue, it is going to be midyear, and I am sure the gentleman from Iowa recognized that many of our rural hospitals operate in such a way that they are not so completely automated and computerized, that it will be a very easy opportunity for them to plug in the new figures midyear for their accounting year.

But it is better to know that there could be a refund for a reimbursement retroactively than to continue to operate with the uncertainty that now perplexes them. So indeed I am delighted to have had the opportunity to participate in this special order and I want to thank you very much for all of the work you are doing to help bring a resolution to this very important issue.

Mr. TAUKE. I thank the gentleman from Nebraska for his comments.

I also want to commend him for the tremendous work that he has done on this issue. Your comments about our understanding of the problem and our desire to work with the Health Care Financing Administration bring to mind something which I do not think anyone has mentioned. That is, a number of us, including the gentleman from Nebraska, worked with the Health Care Financing Administration to try to get those hospitals which had been reluctant to send in information to bring it in in a timely way.

Mr. DAUB. I thank the gentleman.

Mr. TAUKE. We have demonstrated our willingness and desire to work with the Health Care Financing Administation. We want to be reasonable about this.

At the same time, as I said to our other colleague from Nebraska, there is a limit. And I think we have approached that limit. We do not sense the commitment that there should be over at the Department of Health and Human Services to get on with the show.

That is why we are here today, and the gentleman stated it very well. I am delighted to know that he will be adding another voice from another corner of Congress over there on the Ways and Means Committee, which is so critical in determining health care policy, to help us on this issue.

So I thank the gentleman for his comments.

Mr. DAUB. Again I thank the gentleman.

Mr. PENNY. Will the gentleman yield?

Mr. TAUKE. I am pleased to yield to my neighbor to the north, the gentleman from Minnesota [Mr. Penny].

Mr. PENNY. Mr. Speaker, I have spoken often in the past weeks about the crisis facing rural America. I am here again today to address an additional concern—the financial crisis faced by rural hospitals in the west north central region. These hospitals continue to lose money day after day, not because of their own inefficiencies, but because long required and often promised deadlines have not been kept by the Health Care Financing Administration and the Department of Health and Human Services.

When the prospective payment system for Medicare reimbursement was adopted, rural/urban differentials for labor and nonlabor costs were established. Rural hospitals are reimbursed less for the same services than urban hospitals because it is assumed that rural wages and costs are lower. Unfortunately, the formula for determining the differential was flawed and its impact on hospitals in our region was especially great. In the west north central region, urban hospitals receive 5 percent more for standardized labor costs and 54 percent more for standardized nonlabor costs than rural hospitals receive. It doesn't take a computerized cost-benefit analysis to demonstrate that these rural hospitals just can't keep providing service long when they are not being adaquately reimbursed.

In July 1984, the Deficit Reduction Act required the Secretary of Health and Human Services to issue a report to Congress on a revision of the area wage indices within 30 days after enactment. The 30 days passed and no report was forthcoming. In the 8 months since, a bipartisan congressional group under the determined leadership of my colleague from Iowa, Mr. Tauke, has pushed for the release of the report. We are still waiting. Rural hospitals are still waiting. In testimony earlier this week, Secretary Heckler promised that the report would be issued within 2 weeks. I sincerely hope that she finally keeps her promises and immediately acts to implement the new rates. Rural hospitals simply can't afford to wait any longer.

Mr. TAUKE. I thank the gentleman from Minnesota for his excellent remarks and for his commitment to this issue.

Mr. SCHUETTE. Will the gentleman yield?

Mr. TAUKE. I now yield to the gentleman from Michigan [Mr. Schuette].

(Mr. Schuette asked and was given permission to revise and extend his remarks.)

Mr. SCHUETTE. Mr. Speaker, I rise today to voice my concern and express my concern over the urban-rural distinction in Medicare's prospective payment system. Medicare's reimbursement system is predicated on the hospitals' geographic location and mandates lower reimbursement to the rural hospital for the same service per diagnosis-related group, or DRG, as that performed by the urban hospital.

But this urban-rural classification does not take into account costs to the rural hospital that may be beyond its control and therefore cannot be standardized in predetermined Medicare reimbursements.

The present system is inflexible and rural hospitals are suffering.

One such hospital, the Memorial Hospital in Owosso, MI, is in my district. And let me add that under the previous system the Owosso hospital was designated as an urban classification. But now, under the current system, it is a pocket surrounded by urban designation, and it is the sole rural designated hospital surrounded by urban hospitals in the State of Michigan.

This is an inequity that needs to be addressed.

That hospital is but one of the nation's many rural hospitals that has become a victim of Medicare's urban-rural classification. The Memorial Hospital in Owosso, MI, is not alone. Many rural hospitals are losing money in Medicare reimbursements since they must absorb any costs that exceed the Medicare repayments.

It is an inequitable assumption that all rural urban hospitals incur lower costs than all urban hospitals and yet that is the underlying assumption of the Medicare prospective payment system. Many rural hospitals may in fact pay more for goods and services, labor, supplies, and transportation due to the nature of their locale.

The Medicare reimbursement system does not account for regional discrepancies or hospitals located on borderline areas. Instead, hospitals are grouped without regard to particular hospital-specific costs of services.

It is a threat to the quality of medical care and to Medicare services to force rural hospitals to cut corners to assure the coverage of their costs. The prospective payment system must be changed to incorporate the differentials of each hospital, regardless of its urban or rural location. We cannot risk substandard health services in order to accommodate the inflexible classification of Medicare's prospective payment system.

If the question before this body to provide health care is quality health care, and if the question presenting we as legislators is fair and affordable, and quality health care, we must correct, in a prompt fashion, the inequities in the DRG reimbursement system that so adversely affects rural hospitals across this Nation.

Let me say that I join with my colleagues on both sides of the aisle in commending Mr. Tauke for his leadership on this critical issue. I know it is important back home in my State, in my district, and I commend the gentleman very much.

Mr. TAUKE. I thank the gentleman.

Mr. Speaker, clearly the gentleman from Michigan is one of the most promising new Members of Congress, and I am delighted that we have not only his support but his leadership on this critical issue of providing quality health care for rural America.

Mr. GUNDERSON. Mr. Speaker, today I would like to add my words of concern in this special order regarding the wage indices used in calculating Medicare reimbursement under the prospective payment system.

The urban/rural wage distinction used in the reimbursement calculation contains many inequities. Admittedly, urban hospitals do in many cases have higher operating costs, but rural hospitals are being short changed for treatment of Medicare patients under the present method of calculating reimbursement rates. Specifically, the use of outdated Bureau of Labor Statistics data penalizes hospitals in rural areas like western Wisconsin that utilize large numbers of part-time employees. The data lacks information on hours of employment in hospitals. Thus, the wage index totally ignores this important factor in reimbursing rural hospitals.

In addition, a single wage index is used for all rural hospitals in a given State. Therefore, usual variations within a State are ignored by the index, causing rural hospitals to receive DRG rates anywhere from 10 to 30 percent lower than urban hospitals.

In this era of cost containment in health care, we have asked hospitals to make many changes to improve efficiency, and they have responded magnificently. Hospitals are becoming more specialized; home care and skilled nursing facility arrangements with the hospital are becoming more common; and hospitals and doctors are working more closely together. But if the prospective payment system is going to continue to be successful, certain very real problems within the system must be addressed quickly. Especially when we are considering simply freezing the present rate structure for another year, we must address the blatant wage index inequity.

In conclusion, Mr. Speaker, I urge the Health Care Finance Administration to implement new wage indices for Wisconsin hospitals.

Mr. SKELTON. Mr. Speaker, I thank the gentleman for his efforts on behalf of our rural hospitals. Secretary Heckler's pledge to submit the area wage index report to Congress within 2 weeks is attributable in a large part to your hard work on this subject.

Recent administration rhetoric about emergency credit relief for the Nation's farmers has, it seems, been designed to create the impression that rural America is trying to live on the Government dole. Nothing could be farther from the truth. What rural America deserves, is fair treatment from the Federal Government.

Adjustment of the area wage index is a matter of fairness to rural America. Because it fails to account for factors that tend to increase labor costs for rural hospitals, the wage index currently in use is wrongfully depriving those hospitals of millions of dollars in medicare reimbursement. In the region in which Missouri is included, for example, the current wage index contributes significantly to a 25 percent differential in Medicare reimbursement for labor between urban and rural hospitals.

Since Medicare beneficiaries comprise a large part of the patient loads of most rural hospitals, it is essential that they receive adequate reimbursement from Medicare. Otherwise, some rural hospitals may be irreparably damaged and many rural Americans may lose hard-won gains in access to high-quality hospital services. Therefore, I urge Secretary Heckler to submit her report within the 2-week timeframe she has established and to expeditiously implement the revised area wage index.

Mr. Whittaker. Mr. Speaker, when Congress formulated the Medicare prospective payment system, we did so in the interest of efficiency and fairness. Unfortunately, those interests are not being served by the formula under which rural hospitals are reimbursed under this system.

When the Health Care Financing Administration [HCFA] drew up its formula for reimbursing hospitals for average costs, it attempted to account for differences in costs of living from one geographic area to another. The idea was that a hospital in a rural area could pay its health care staff less than a big city hospital. At first glance, it appears to be a sound idea and HCFA was faithfully carrying out Congress' orders.

But, there's a catch to it. In figuring average labor costs, HCFA did not take into account part-time versus full-time employees. HCFA took Bureau of Labor Statistics figures for a hospital's total payroll, divided by the number of employees. Due to the fact that rural hospitals have a greater number of part-time employees, a rural hospital's average labor costs are skewed. Under HCFA's original formula, the average wage for rural hospitals is artificially low. For that reason, rural hospitals are shortchanged under the prospective payment system.

Congress moved to correct this inequity in 1984. Last year's Deficit Reduction Act instructed Health and Human Services Secretary Heckler to recalculate the wage index for rural hospitals, taking into account part-time employees. Since then, HHS has missed two deadlines to revise the index and bring fair and equitable treatment to our rural hospitals. We hope they don't miss a third. Last Thursday, February 28, Secretary Heckler assured the Appropriations Committee that her department would have the new regulations within 2 weeks.

It's important to rural hospitals which are already struggling with the costs of providing quality health care in Kansas and other States that HHS issue the new, equitable wage indices in the next few days and then act to implement them swiftly.

We're counting on you, Secretary Heckler. Don't let rural hospitals and their patients down, don't let your friends in Congress down.

Mr. Lightfoot. Mr. Speaker, since taking office in January, I have been working with many of my Midwestern colleagues to correct the inequities in Medicare's prospective payment system for rural hospitals. As many of your might know, since the implementation of this new system, rural hospitals have received an extremely unfair and unjust reimbursement rate for providing Medicare services to older persons.

When the Department of Health and Human Services determined the reimbursement rates in 1983, they divided the country into nine regions and then within those regions differentiated between rural and urban areas. The rates were then based upon where a hospital was located.

So, for example, a hospital within my district, such as the Clarke County Public Hospital in Osceola, IA, would be used the rural reimbursement rates for the west north central region. Now, that sounds fine, until you look at what this hospital would receive compared to what an urban hospital, such as one in the Des Moines area, only 40 miles away, would receive.

In the case of the Osceola Hospital, under figures from last year, it received $1,960 for DRG No. 127, which is for heart failure and shock, while a Des Moines hospital received $3,161 for the same procedures. That's a 61 percent difference. Now, I admit that there are some cost differences between a rural area and an urban area, but not a 60-percent difference, especially for hospitals located 40 miles apart.

The differences between rural and urban areas is attributed to the differences in nonlabor and labor costs. Upon close examination, however, one finds that these differences are not that great. Common sense will tell you that. For instance, rural hospital costs for nonlabor items, such as supplies and utilities, might often be higher than the costs experienced by urban hospitals, which can order in larger quantities and which might get a break on energy costs because of higher energy usage.

In the area of the labor component, a case might be made for differences in labor costs between a rural area and an urban area, but again not such a large difference. What has not been taken into consideration is that rural hospitals often hire more part-time help and compete for skilled labor in an urban market. These factors have not been taken into account, which has created a flawed reimbursement formula for Medicare services.

Now, almost everyone admits that the reimbursement formula is flawed and needs to be corrected. For the past several months, many Members of Congress, led by my distinguished colleague from Iowa, Mr. Tauke, have pressed Health and Human Services Secretary Margaret Heckler for a correction in the formula. On several occasions, Secretary Heckler has promised to send a report to Congress revising the reimbursement formula for the labor component, but as you know, we are still waiting for it.

This report is more than 7 months overdue, and I am hopeful, along with many of my Midwestern colleagues, that HHS will release this report soon. Small, rural hospitals should not have to suffer further under this flawed reimbursement formula. All of the hospitals have tried to work under the regulations for the new system, and all they want is to be treated equitably.

If this reimbursement formula is not corrected, we could possibly see many rural hospitals forced to close. A recent study by the Health Policy Corp., of Iowa shows that at least 32 of Iowa's small hospitals suffered operating losses during 1983. The figures for 1984 have not been compiled, but it is estimated that they will be even bleaker. The longer the report is delayed, the gloomier the picture will become. Hospitals have already waited for over a year for a correction in the formula, and they should not have to wait any longer.

If rural hospitals are forced to shut their doors, we will see a swift deterioration in health care services for Medicare patients. These hospitals provide an invaluable community service, and without them, many elderly Medicare patients would probably be denied health care services or would have to drive many, many miles to receive care because of the medical profession's hesitancy to service communities without hospitals. We cannot let this happen.

I am encouraged, however, by recent news from Congressman Tauke that the report revising the area wage indexes should be sent to Capitol Hill in a few weeks. While this is heartening news, I will not be satisfied until the administration and Congress signs off on the report and until rural hospitals are operating under a revised reimbursement formula. Rural hospitals are not asking for a special deal, they only are asking for a fair deal.

At this time, I would like to commend Congressman Tauke for his efforts to correct this faulty formula, and I intend to continue working with him and the rest of my colleagues in the House to get a fair Medicare reimbursement formula for Iowa's small, rural hospitals. The injustices that have occurred against rural hospitals must not continue.

[From the Congressional Record, Mar. 28, 1985]

RURAL HOSPITAL PROBLEMS WITH REIMBURSEMENT UNDER MEDICARE

The **SPEAKER** pro tempore. Under a previous order of the House, the gentleman from Iowa [Mr. Tauke] is recognized for 60 minutes.

Mr. **TAUKE**. Mr. Speaker, first I want to thank you for your indulgence in deferring your own special order in order to give those of us who want to speak on the rural hospital issue an opportunity to address this question.

Mr. Speaker, a few weeks ago we took the floor to talk about the problems facing our rural hospitals and the unfairness of the prospective payment reimbursement system under the Medicare Program.

Since that time we appear to have taken one step forward, but also one step backward. To refresh your memory, the Medicare prospective payment—or DRG—reimbursement system was imposed a few years ago by this Congress in order to try to ensure that we had a fair system and a more cost effective way for reimbursing hospitals for their Medicare services.

Rural hospitals and others, however, have received an unfairly low reimbursement under the DRG reimbursement system. As a result, some of our rural hospitals are in deep trouble. They simply are not receiving the payments under Medicare that they need in order to keep their doors open.

We have recognized this problem in Congress, and we have pinpointed a good portion of the problem as attributable to the flaws in the area wage index which make up a portion of the DRG under the prospective payment system. The area wage index is faulty. In the last Congress we mandated in the Deficit Reduction Act, passed in July 1984, that the Secretary of Health and Human Services issue a revised area wage index within 30 days of the adoption of that act.

Well, that deadline has come and gone. It came and went late last summer. Subsequently, the Secretary of Health and Human Services said, "We will have the report out by the first of January." The first of the year arrived and no report. Then she said the end of February. The end of February came. No report. Then she told a subcommittee of the Appropriations Committee "2 weeks." Two weeks went by, still no report.

Now we understand that the Department of Health and Human Services will deliver the report to Congress before the week is out. If indeed this latest deadline is met, that will be a step forward.

But at the same time I received a letter this week from the Director of the Health Care Financing Administration, Carolyne Davis. Now, Dr. Davis is an outstanding public servant for whom I have great respect. But she indicates in this letter that although we are not going to get the report of the revised area wage indices, we are not going to implement that report until at the earliest the first of October. Instead of having a separate rulemaking that would put the revised area wage indexes into effect, correcting as a result these flawed reimbursements as quickly as possible, the Department has decided to delay the implementation of the new wage reimbursements until sometime later on this year.

It seems to me that it is unconscionable for us, when we recognize that there is a serious flaw in the current reimbursements; when we know that a number of hospitals are facing great financial difficulties as a result of this flaw; and when we have the data now available to us to correct this problem, not to do so.

So today I have joined and I am joining again with my colleagues in calling on the Department of Health and Human Services to rectify the wrong which the Congress has recognized and has mandated be corrected, which the Department says it recognizes and wants to correct. We want that wrong rectified as quickly as possible.

I am pleased now to yield such time as he may consume to the gentleman from Texas [Mr. Stenholm], who has been very helpful in this effort to try to correct this serious problem.

Mr. **Stenholm**. I thank the gentleman from Iowa for recognizing me.

Mr. Speaker, I commend the gentleman for his continuing leadership which he has shown in regard to this matter.

Mr. Speaker, while I appreciate the opportunity to join my colleagues here today to speak in behalf of America's rural hospitals, I am very disappointed that the reason for this special order is a continuing lack of response by the Department of Health and Human Services in releasing the report that examines the rural/urban differentials in the formula for Medicare reimbursement to hospitals. I am even more dismayed by Administrator Carolyne Davis' recent letter to my colleague from Iowa, advising that the Health Care Financing Administration (HCFA) has no intention of publishing revised regulations on this issue until all of the proposed notice of payment rates are published this fall. I cannot help but wonder whether it is a lack of accurate information or an outright disregard for the health care of rural Americans that is behind the administration's refusal to take prompt action in this matter.

If the problem is a lack of information, I wish I could take HCFA officials down to the 17th District of Texas to visit with my rural hospital administrators, who have made it very clear to me how desperate their situation is. Today was a very typical day for me as I sat down to review my morning mail. Included in the stack were no less than five letters from health care related individuals begging for the relief that will enable their communities to keep their hospitals. Listen to what some of my constituents are telling me:

"I am the administrator of a very small rural hospital. We have a very capable physician in our community. I believe he is an ethical man; he still charges only $10.00 per office visit. When he admits a patient to our hospital, he feels that hospitalization is needed. Our hospital just barely has enough money to buy supplies and pay our employees. If our hospital should be forced to close, the physician would leave, in my opinion the nursing home would be forced to close and the pharmacy would have to close. Our elderly perople would be forced to drive 30 or more miles for medical care or even to have a prescription filled."

A hospital administrator from another rural county provided me with this information:

"Attached you will find a brief study which compares the Medicare payment for 20 DRG's in our hospital compared to an urban hospital. The difference in total reimbursement is 53 percent. In other words, the Federal Government is saying that rural hospitals in Texas, who must meet the same Medicare standards, pass the same Medicare inspections, employ the same skilled personnel, treat and compete for patients equally, must do this for 53 percent less."

Another constituent, a physician, outlines a very disturbing scenario that he foresees:

"Needed services will be removed from those persons who can least afford the loss, the elderly and the rural poor. It is these people, who are least able to afford the costs of travel to and from urban centers, who are hurt the most. Many of those people will simply forego the needed care and thereby reburden the system and themselves. Victims of farm, ranch and other industrial accidents will also be deprived of their first contact emergency care. Prenatal care and normal obstetrical service would be removed."

This physician concluded with the warning:

"An emergency does exist! There is no time for usual 'study of studies' procedures, or the damage will be irreparable. Some decisive step must be formulated and put into effect to save the hospitals and all attendant and dependent services for the rural counties."

I will not attempt to improve on these graphic descriptions of the importance and necessity of our rural hospitals. I only ask that all of the proper officials in the administration listen to these warnings. If the endless testimonies such as these cannot persuade those officals to implement changes, I can only conclude that it is not a lack of information, but, indeed, a disregard for the health care of rural Americans that is the problem.

Presumably, HHS has studied, examined and reconsidered the DRG formulas used for rural hospitals. Once again, I join my colleagues in demanding that the Administration release the report that was due seven months ago, and respond by implementing in an expeditious manner those regulations that will enable rural hospitals to survive.

I thank the gentleman for yielding.

Mr. Tauke. Mr. Speaker, I thank the gentleman from Texas for his excellent comments.

Mr. Speaker, as the gentleman pointed out, there is very strong reason for implementing the revised area wage indices as soon as possible. First of all, the hospitals that the gentleman describes are the most efficient hospitals. So we want to keep those hospitals in business, not have the system put the most efficient out of business and keep the least efficient in business.

Yet if the Department does not move forward quickly to save our most efficient, cost-effective hospitals, we are going to have a very serious health care problem in rural areas, a health care problem that will also cost the Federal Government more money in the long run.

Second, Congress has mandated that we implement these indexes as soon as possible.

Finally, under the Deficit Reduction Act, we said that once the new area wage index is implemented it should be retroactive to the time the prospective payment system first went into effect. Now if we delay that implementation any longer, the impact of the retroactivity on the hospitals that have been overreimbursed during the last several months will be much greater.

Mr. Speaker, I yield to the gentleman from Kansas [Mr. Roberts].

Mr. Roberts. I thank the gentleman for yielding.

Mr. Speaker, I want to commend the gentleman from Iowa for his leadership in this area.

Mr. Speaker, nearly 3 weeks ago my colleagues from rural areas were here during a similar special order to discuss the failure of the Department of Health and Human Services to release a congressionally mandated report on a wage index used to reimburse hospitals for services they deliver under the Medicare Program.

I stated at that time I would come to the well of this House on a regular basis until the folks at HHS released its long-promised report. Our presence here today is to remind our colleagues that our rural hospitals remain hostage.

In my mail earlier this week was word from our colleague Mr. Tauke that the Health Care Financing Administration has stated it will not be proposing any changes in the area wage index until the proposed 1986 prospective payment rates are published later this year and, if accepted, not implemented until October 1 at the earliest.

To put is simply, this is not acceptable. Our small, rural hospitals and the citizens they serve are at jeopardy. In Kansas, our hospitals are losing, on the average, nearly $20,000 every day this wage index is withheld. It's not fair and this Member intends to turn up the heat to get some action.

There is no legitimate reason not to move forward with the revised wage index. Survey after survey has been conducted and the results are in. I strongly urge our friends at HHS to reconsider their position and move forward to correct this inequity. Further delay will only cause further hardship on our rural health care delivery system. It is a simple fact that some providers cannot survive any more delay.

Mr. Speaker, that is the end of my prepared remarks. I would say that I have an additional concern: It seems to me that this body, we come here to legislate, that is what most people think we do back here and they probably think we legislate too much; but I want to tell my colleagues and my friends that most of what we do, 60 percent of my staff's time is spent trying to be a court of last resort in behalf of people when we find all these alphabet-soup agencies around town doing things to people, as opposed to for them.

Now you know the argument and the gentleman knows the speech; "these are somehow nameless and faceless bureaucrats down at HHS or H2S or HEW," it does not make any difference what acronym you use, but these are not nameless, faceless bureaucrats. They are good people, they are experienced people. I cannot understand for the life of me why we cannot make this decision. I suspect that we are seeing the sly hand of OMB here, that great policymaking body, the Office of Management and Budget actually making this decision.

This is nothing new under this administration. As my colleagues will recall, under the previous administration, we went through something in our rural areas called hospital cost containment. It sounded wonderful except for the fact we would have been denying our rural hospitals essential services; we would have had to close them down.

Then we had something called utilization review, where if your broken arm did not meet the federal guidelines, you would not be admitted to the hospital, at least to the extent that let's say Medicare would pay for it.

In our rural areas, they said, "We need three doctors in very clinic to review every admission, every 24 hours." How do you do that in a one-doctor clinic?

Then we went through something called health planning guidelines, and as my colleague will remember, there was some person down at H2S or at that time HEW and said. "Well, unless your OB unit has a delivery kind of index there where your are going to deliver 500 babies a year, we are going to close it down." well, there would have been a lot of babies born in pickups in my county were that the case.

I just want to tell my colleagues that in regards to this particular decision, I am not only fed up, I am not only sick and tired of getting this repeated answer back from H2S that they cannot seem to get the report out; I am tired of being sick and tired.

Why cannot the secretary meet with us as our colleague, Mrs. Smith of Nebraska has suggested? She is a former Member of this body; all I urge her to do is come and listen to the music. She does not even have to dance with us. Why for does she do us like she does?

I just would say to my colleague, I would hope that this meeting could be held soon, and I hope we can certainly put an end to this situation, or we will find ourselves here once again with another special order, and once again delays costing our rural hospitals and our rural patients.

I commend the gentleman for his fine leadership in this regard.

Mr. TAUKE. I thank the gentleman, and I want to point out, after he mentioned the Office of Management and Budget, that it is not just our rural hospitals and our patients that are being affected by this; they will not be the only ones to bear the cost; this Government and its taxpayers will also bear the cost. Because if we put our lowest cost hospitals out of business, it means patients will travel to higher cost hospitals, and we will be picking up the tab at those higher cost hospitals.

So it is in everybody's interest to do what Congress has already mandated. I agree with you; I do not mind making the policy; but I really do get sick and tired after a while of beating up on agencies, trying to make them do what they are supposed to do anyway.

I thank the gentleman for his help and contribution.

I yield to the gentleman from Iowa [Mr. Lightfoot].

Mr. LIGHTFOOT. I thank the gentleman for yielding to me.

Mr. Speaker, once again we find ourselves here on the House floor to plead with Secretary Heckler to release that report which does revise the hospital weighted indexes under the prospective payment system.

At the same time, we are also pleading with her in the strongest possible terms to implement the indexes once that report is released.

It has already come to my attention that the Department of Health and Human Services plans to publish those revised wage indexes for public comment as a part of the proposed notice of payment rates on October 1, 1985.

Unfortunately what that means is that rural hospitals in our districts will not see relief until October, and that is at the earliest. This is just unconscionable; my colleagues and I will not stand for it.

For over a year and half now, rural hospitals have been operating under a flawed reimbursement formula under the prospective pay program. These hospitals have tried to continue to provide community-based quality health care services; to implement the new Medicare system.

They made a good faith effort to abide by the rules, but I am sure everyone agrees that there is limit to what these hospitals can do; and they cannot continue to operate under this punitive formula.

The viability of these hospitals is at stake if the indexes are not published soon, and implemented immediately. Rural hospitals have been waiting several months for a correction of the reimbursement formula, and so has the Congress.

Last year, Congress directed HHS to develop a revised set of indexes, to take into account full-time versus part-time employment practices. Congress mandated the Health and Human Services bureau to report back within 30 days. Needless to say, that deadline was missed.

Then they promised a group of my Midwestern colleagues that they would have the report by December 31, and again that deadline was missed. Finally, when Secretary Heckler testified before the Committee on Appropriations on the 1st of March, she said Congress would have the report within 2 weeks. As we know, that deadline has elapsed as well.

Then still without the report, we are told that there are compelling reasons why the revised wage indexes should be incorporated into the yearly publication of proposed rulemaking for the prospective payment system. We are told this is to give interested parties the opportunity to comment.

I guess that Health and Human Services has basically failed to consider our compelling issues for immediately issuing the regulations implementing the expected report. I do not know how we can make it any clearer; our rural hospitals have waited long enough for a fair reimbursement rate.

I do not know how we can make it any clearer that Congress wanted this flawed reimbursement formula corrected right away and not a year later. I agree with Health and Human Services that interested parties should be given a chance to comment on the revised wage indexes, but I do not see what is wrong with letting them comment right now rather than much later. I do not see what is wrong with issuing a separate rulemaking for these revised indexes.

If a separate rulemaking is published, both our concerns in Health and Human Services will be met. Interested parties will have the opportunity to comment, and rural hospitals would be given relief sooner.

So once again, I strongly implore Secretary Heckler to release that report, and to issue a separate rulemaking immediately so that rural hospitals will finally receive the much-needed relief that is owed to them.

I might add to that, as my colleague, the gentleman from Iowa [Mr. Tauke] is well aware, with the economic situation we have in our State in particular, this also has impact on our small hospitals and if this thing continues on the road that it is on, what do you do when you are 65 or 70 years old and the wind is out of the north and it is 25 below zero, and you have to drive 150 miles to get health care; because that is the net result of what this is going to be.

We need some action, today.

Mr. TAUKE. I thank the gentleman for his excellent comments.

I now yield to the gentleman from Kansas [Mr. Whittaker].

Mr. WHITTAKER. I want to thank my colleague for his continued leadership and initiative on this very vital issue.

Mr. Speaker, I am more than happy to join several of my colleagues in a special order to address the problem of reimbursing rural hospitals in a fair and equitable manner under the Medicare prospective payment system.

My colleagues are well aware that hospitals located in rural areas are receiving substantially less in Medicare reimbursement than those hospitals located in urban areas. This is not because they do not provide equal care, but because of a seriously flawed area wage index used in calculating prospective payments under the Medicare Program.

Members representing rural areas have wrestled with this inequity for more than a year, but we were cautiously optimistic when we were told 3 weeks ago that a congressionally mandated report on revised area wage indexes would be before Congress within 2 weeks. We joined our good friend, Congressman Tauke, who has been so diligent in pressing for release of this report, in encouraging Secretary Heckler to release the report and to immediately issue proposed regulation for the implementation of the revised indexes.

I had hoped that we would not have to be here again pushing for action on this issue. But here we are, still without a report, and instead with further disurbing news that HCFA intends to delay implementation of the revised area wage indexes by including them in the notice of proposed rulemaking for fiscal year 1986 prospective payment rates.

This delay in implementing the new indexes only pushes many of our rural hospitals closer and closer to shutting their doors for good. Mr. Speaker, I am astonished that the Departrment of Health and Human Services continues to defy a congressional mandate to correct this problem, and to correct it retroactively to October 1983. I can only wonder how many more ways HHS can find to further delay fair an equitable treatment of our rural hospitals.

Every day that HHS delays implementing the new indexes, our rural hospitals are forced to make up for the deficiencies in Medicare payments through added charges to other patients, every day HHS delays, our rural hospitals are forced to endure and struggle to keep pace with rapid changes and in some cases fight to keep their doors open 1 more day; every day HHS delays, I become more and more dismayed and angry at their deliberate defiance of a congressional mandate.

Once again, we are not asking for special treatment of our rural hospitals. We're asking for fair treatment. We are asking that HHS follow congressional will, implement the new area wage indexes and stop these deficient payments to our hospitals. Our rural constituents deserve the same availability and quality of care as their urban neighbors and this continued bureaucratic foot-dragging denies them that right.

How many times have you said to yourself, "There oughta be a law?" Well, in this case, there already is a law. How many times must we tell Secretary Heckler, "You oughta obey the law."

Mr. TAUKE. I thank the gentleman. His remarks are right on target, and I think that he makes a good point. We are not asking to spend any additional money, nor are we asking for any special favors. All we are saying is that we know the way in which we reimburse hospitals now. The way in which we spend funds correctly is flawed. We are not trying to expand the pool; we are trying to make sure that the way the pool is divided is more accurate and fairer.

So I appreciate the comments of the gentleman.

Mr. Speaker, I yield to my colleague from Nebraska [Mr. Bereuter].

Mr. BEREUTER. I thank my colleague from Iowa for taking this special order and for the leadership he is bringing to try to resolve this inequitable situation.

Today again I rise to protest the flagrant disregard by the Department of Health and Human Services for a fair and equitable resolution of a serious problem in the structure of the prospective payment system.

Many of this Member's colleagues know the rural hospitals are in trouble because of the formula used to determine Medicare reimbursements. Because of a number of factors, including the higher percentage of part-time employees in rural hosptials, the wage-labor index that determines the reimbursements under the prospective payment system is seriously flawed.

In my State, for example, we are said to have the lowest hospital costs or perhaps second lowest of the 50 States. Anyone familiar with our State knows that is absurd, but a major flaw in this system counts all of the part-time employees' salaries as being full-time equivalent. My State happens to have the highest percentage of employees, apparently, who are part-time employees working in those hospitals. So this has been one of the major factors why this formula is seriously flawed.

For almost 2 years now Members from rural States have been working to correct the labor-wage index. A report was promised by the Department of HHS. To that end, the Department conducted studies. They conducted audits. They requested data. They called for adjustments. They met with hospitals. They met with administrators. They convened a special task force and held meetings. A new labor-wage index was reportedly developed. That information, however, languished on the desk of HHS officials for months and months. Members pressed for the release of the revised, fair an equitable figures. Three times the report was promised. Three times HHS failed to deliver—of course, always with an excuse of questionable merit. At the end of February, a solemn promise was forthcoming from the Secretary. Yes, she assured us, the long-awaited report would be released by the middle of March. Now we are told the report is pending action in the Office of Management and Budget. This Member, however, remains skeptical about the latest promises.

Certainly some small rural hospitals that have been struggling for survival cannot withstand the additional months of underreimbursement while the rules are being promulgated. Therefore, this Member stands here today in the well to serve notice to the Secretary of HHS that, since previous attempts to secure her favorable attention have obviously failed, this Member will attempt to secure her attention by influencing appropriations for her Department. This Member is going to continue to badger HHS on this issue until there are favorable results. Certainly there is a tremendous waste of Federal moneys in the workings of certain offices within Health and Human Services.

Let there be no misunderstanding, this Member is prepared to take the rest of the term if needed to be sure that the funds that have been appropriated to support the stalling and posturing from the Department of Health and Human Services are held up or are not appropriated again. I will consult with our colleague on the Appropriations Committee from Iowa [Mr. Smith] as to where attention-securing and action-securing budget cuts in the bureaucracy of HHS can be made.

Next week this Member will be in the well again if necessary. Next week this Member will report on his efforts to gain the attention of the Secretary of Health and Human Services here in Washington. This Member invites a response from other Members with rural hospitals who have ideas that could be used to force HHS to pay attention to our plight and to keeping their promises.

The old platitude fair is fair bears repeating here. A revised index may mean hardship for some overreimbursed hospitals for a time. Be that as it may, until corrections are made, the index as it stands means terrible hardships for many struggling rural hospitals. And it means hardships that are delivered in an inequitable fashion. This Member and others who have spoken here today are just the tip of the iceberg of people who are concerned about their constituencies and the effect of this very unfair formula on rural hospitals across the country.

I say to the gentleman from Iowa again: Thank you very much for your continued leadership on this. We will work together until we get a resolution that is fair to our constituents and that implements the law that Congress has passed.

Mr. TAUKE. I thank the gentleman for his comments. As you begin that appropriations battle, count me in.

Mr. Speaker, I yield to the gentleman from Kansas [Mr. Slattery].

(Mr. Slattery asked and was given permission to revise and extend his remarks.)

Mr. SLATTERY. I thank the gentleman for yielding, and I for one really appreciate your leadership in this.

Mr. Speaker, the adjustment of the area-wage index is of vital importance to many hospitals in Kansas. If this fundamental inequity is not addressed, Kansas hospitals are projected to lose an estimated $12 million during the first 4 years of the Medicare prospective payment program.

I am surprised that we are here to consider an issue that the Congress wanted settled nearly 6 months ago. Yet, it is my understanding that the Department of Health and Human Services intends to include the revised area-wage index in its notice of proposed rules for the fiscal year 1986 prospective payment rates.

I cannot accept the department's plan to delay implementation of the revised area-wage index until October 1985, this issue has been on the front burner since the initial implementation of the prospective payment system in October 1983. Congress recognized the need for changes in the wage index through provisions of the Deficit Reduction Act of 1984. And, the issue has essentially been resolved since the beginning of calendar year 1985. What does the Department of Health and Human Services hope to achieve by continuing to drag its feet?

Apparently, the department believes that by prolonging implementation of the revised index, it will ensure the public right to offer informed comments. This is an admirable consideration on the part of the department. However, it seems to me that a 30 day comment period now provides the same opportunity for informed public comment as a 30 day comment period in September. And, while speaking of public rights. I wonder what rights this delay provides rural hospitals who should receive equitable medicare reimbursement? The question is a compelling one, brought on by the insensitivity of the Department of Health and Human Services to resolve this basic inequity in the structure of the prospective payment system.

Further compounded by the delay in implementing the revised area-wage index is the retroactivity requirement of DEFRA. The implementation of the revised area-wage index will require many hospitals to repay overpayments resulting from the current, flawed index. Hospitals at both ends of the spectrum are and will be unduly affected by the inaction of the Department of Health and Human Services.

Should the department fail to correct the inequities of the current area wage index as quickly as possible, the difficulties all hospitals face will be extended—particularly in light of changes proposed in the Medicare Program for fiscal year 1986.

I believe that when the questions of fairness and equity are posed, both rural and urban hospitals will benefit in the long run from the prompt implementation of the revised area-wage index. The equal opportunity to adjust to the prospective payment system is paramount to the overall success of the program. This opportunity, however, will not be realized if the Department of Health and Human Services continues to withhold the immediate implementation of the revised area-wage index.

Thank you, Mr. Speaker.

Mr. TAUKE. I thank the gentleman and all of our other colleagues who have taken time on a busy afternoon to come to the floor and make comments on this issue.

Mr. Speaker, I include for the RECORD at this point a letter that I received from Dr. Carolyne K. Davis, Administrator, Health Care Financing Administration, Department of Health and Human Services, and my letter to her dated March 25, 1985:

HEALTH CARE FINANCING ADMINISTRATION,
THE ADMINISTRATOR,
Washington, DC.

Hon. TOM TAUKE,
House of Representatives, Washington, DC.

DEAR TOM: This is in response to your letter concerning our progress toward implementing revised hospital wage indexes for use in the Medicare prospective payment system [PPS]. You would like us to implement these revised wage indexes using a separate earlier rulemaking process rather than including them in the proposed rulemaking for the fiscal year 1986 prospective payment rates.

I want to assure you that I remain committed to the adoption of improved hospital wage indexes for the Medicare PPS. However, because a revised wage index will result in changes in the payment rate for many hospitals, we believe there are strong arguments for publishing revised hospital wage indexes for public comment. Similarly, there are compelling reasons why revised wage indexes should be published as part of the proposed notice of payment rates to be implemented October 1, 1985. PPS is based on the prospectivity of rates, i.e., new rates are published prior to their implementation so that interested parties have a chance to comment. We believe that informed comments can best be furnished when interested parties are able to analyze and evaluate at one time all the proposed components of the payment formula. In this way, they can assess the total impact of the payment changes.

I also understand you desire to have improved hospital wage indexes which resolve the part-time employment problem implemented as quickly as possible because of the expected way in which this would benefit hospitals in a number of areas. It is understandable that once an improved system is developed, it should be implemented as soon as possible. However, in determining the course we are to pursue, we must balance the advantages to be gained by immediate implementation against the public right to offer informed comment on the revised system.

Sincerely yours,

CAROLYNE K. DAVIS, Ph.D.

CONGRESS OF THE UNITED STATES,
March 25, 1985.

CAROLYNE K. DAVIS, Ph.D.,
Administrator, Health Care Financing Administration, Washington, DC.

DEAR CAROLYNE: I am frankly dismayed by your letter of March 19, 1985, indicating that it is your intention to delay the implementation of the revised area wage indices by including them in the notice of proposed rulemaking for the fiscal year 1986 prospective payment rates.

The case for moving forward as quickly as possible with an earlier rulemaking process is very strong:

First, the Department of Health and Human Services has already failed to meet Congressionally mandated deadlines for the publication of the area wage index report. It is not possible to justify further violation of the intent of Congress when it can be avoided;

Second, Congress clearly intended that the prospective payment rates be based on the best data available. When that information is available, common sense and Congressional intent mandate that it be used;

Third, Congress has mandated that the revised payment schedules be implemented retroactively. Further delay will impose greater hardships on those hospitals which are receiving larger-than-justified payment rates; and

Fourth, some health care providers cannot survive additional delay.

I do not understand your argument that separate rulemaking compromises the "public right to offer informed comment" on the system. Separate rulemaking will not deny the opportunity for public comment; it will simply require that those comments be offered sooner.

No one can argue that Congress mandated the area wage index report be published late last summer in order to have it languish awaiting the proposed rulemaking for fiscal year 1986. Instead, it is clear that Congress anticipated that the revised payment schedules would be implemented as soon as possible; i.e., we anticipated separate rulemaking.

I strongly urge you to reconsider your decision.

Warmest personal regards.

Sincerely,

TOM TAUKE,
Member of Congress.

Mr. VOLKMER. Mr. Speaker, we all know there are hospitals facing financial hard times. And we all know that many of those the hardest hit are in rural America. Last year Congress acted to address at least a portion of the problems causing financial hardship for rural hospitals by mandating deadlines for publication of the wage index report. This data would be used to bring rural wage indexes for the Medicare prospective payment system into line so that quality health care can be maintained. But Health and Human Services has failed to act. What Congress has mandated, this bureaucratic agency has chosen to ignore.

In making this mandate we weren't trying to saddle the agency with make-work duty; we weren't trying to give rural hospitals advantages over urban hospitals; we weren't trying to hand tie the efficient operation of health service providers in this country. Our intent was simple. Under the prospective payment system as it is now structured, a hospital's reimbursement depends not only upon how well it provides services, but depends instead on the location of the hospital. Hospitals located in rural areas receive substantially less in reimbursements than those located in urban areas on the assumption that labor costs are substantially lower in the rural areas than in the urban areas. The key phrase here is substantially lower. They aren't. The wage index report will verify that, if only we could have the wage index report published.

But instead of a report we are getting an agency whose hands appear to be tangled by its own bureaucratic redtape. In fact, it appears the agency is hiding behind the regulatory process by refusing to propose a separate wage index for rural areas despite instructions from Congress.

The result of this delay is a financial straitjacket binding many of our rural hospitals. Some may not survive.

Just this week I received a letter from the administrator of a hospital in my Missouri district. He writes, "Congress has placed a considerable burden upon rural hospitals * * *." That administrator knows the problem and he foresees the results. But what he doesn't know, and won't know if it is up to those in charge at Health and Human Services, is that Congress has taken action. But this agency has refused to take notice of that action.

You can be assured I will tell this administrator that the problem lies not with Congress but with this bureaucratic agency. Of course that explanation won't save his hospital. The action by Congress could save it but not if Health and Human Services refuses to carry out the will of the Congress.

On behalf of the rural hospitals of America, on behalf of those who use or will use the facilities provided by those hospitals, and on behalf of the many who will be without health care if action is not taken now, I strongly urge Health and Human Services to comply with the orders of this Congress and not let rural America continue to suffer.

Mr. SKELTON. Mr. Speaker, I thank the gentleman from Iowa for his efforts on behalf of our rural hospitals. That we have any response at all from the administration on the area wage index problem is due to your persistence.

As far as I am concerned, the low priority Dr. Davis has assigned to adjusting the area wage index is indicative of the administration's condescending and contemptuous attitude toward rural and smalltown America. Regardless of the problem, the administration's message to rural America is the same: "Don't bother us with your complaining."

We in rural America do not believe we should be treated in this fashion. We know we are not the cause of this Nation's problems, and we are more than willing to do our share to help make America strong and prosperous. All we expect from the Federal Government is that it will not ignore problems we believe are as significant as any facing the Nation.

I, for one, believe it is time to make the administration understand that rural America wants no more than what we deserve, but, that we will accept no less than that to which we are entitled. Toward that end, I have introduced legislation designed primarily to insure fairer treatment of rural hospitals by Medicare. My bill, H.R. 1682, eliminates the arbitrary urban/rural payment differential from the prospective payment system and orders the Secretary of Health and Human Services to adjust the area wage index for the affects of the use of part-time employees by rural hospitals. Additionally, H.R. 1682 would make payments to all hospitals more equitable, without increasing Medicare's expenditures, by blending national DRG rates with hospital-specific payments.

I invite all of my colleagues who are here today to express concern about Medicare's treatment of rural hospitals to join me in cosponsoring H.R. 1682.

Mr. **Weber**. Mr. Speaker, I would like to share some disappointing news with my colleagues about the inequities rural hospitals are facing. The prospective payment system's reimbursement of hospitals is based on where the hospital is located. The "rural/urban differentials" in the system reimburse hospitals in rural areas less for the same services per DRG than hospitals in urban areas, on the assumption that rural wages and other costs are lower than those in urban areas. Second, the rural/urban differential for labor and nonlabor costs are greater in our west north central region than in any other region of the country and greater than the national average. Urban hospitals receive 25 percent more for standardized labor costs and 54 percent more for standardized nonlabor costs than rural hospitals receive. Congress recognized the problem in the Deficit Reduction Act, enacted in July 1984. The Deficit Reduction Act requires the Secretary of Health and Human Services to issue a report to Congress on a revision of the area wage indices within 30 days of enactment. The Secretary missed this deadline three times. We can't let this go on and on. The Secretary must immediately initiate the process for implementing the new indices.

Some rural hospitals have had to lay off up to a third of its staff. Despite the slashed payroll, these hospitals continue to limp along. These hospitals are faced with a very serious question. Will they have to close their doors? Closing a hospital would have a terrible impact in some towns. Most community hospitals have to provide services to surrounding areas. If these hospitals fail so will the community. Rural hospitals are struggling to survive. They need immediate relief.

I am happy to join my colleagues in this battle to ensure equity and fairness for our rural hospitals.

Thank you, Mr. Speaker.

Mr. **Stangeland**. Mr. Speaker, it is indeed an honor to join my colleague, the gentleman from Iowa [Mr. Tauke] to condemn the Health and Human Services' fourth delay in correcting the revised hospital wage indices by postponing the corrections until October 1, 1985.

This is a case of adding insult to injury. The inequities in the prospective payment system's treatment of rural hospitals are not enough. Now, HHS again refuses to correct the wage indices for another 7 months. Masking its procrastination under the guise of violating the public's right for sufficient time to comment, the agency has decided to delay the rulemaking needed to put these badly needed revised indices in place.

The commenting public HHs is so worried about will be the ones who are now suffering because of the present rural/urban differentials where rural hospitals in rural areas are reimbursed less for the exact same services per DRG than hospitals in urban areas.

During the last Congress, this august body, recognizing all the problems, included a provision in the Deficit Reduction Act mandating that the Secretary of Health and Human Services issue a report to Congress on a revision of the area wage indices within 30 days after the enactment. Time and time again, the Secretary has failed to meet the deadlines which she, herself, has requested. It is imperative that this fourth deadline be kept.

Rural hospitals are struggling to survive under months of underreimbursement. They need the most immediate relief possible. At issue is not only maintaining support for the Nation's rural hospitals, but also the prerogatives of the Congress to assure that the laws it writes are properly executed.

I applaud my colleague, Mr. Tauke, for his lead and superb efforts on behalf of our Nation's rural hospitals. I join with him and my other colleagues, representing districts with rural hospitals, in pressing for the immediate release and swift implementation of the revised area wage indices.

Mr. SCHUETTE. Mr. Speaker, I wish to again express my concern over the crisis now facing rural hospitals across the United States due to the inequitable disparities in Medicare's prospective payment system. Present law mandates two different payments for the same diagnosis, diagnosis-related group [DRG], depending on the hospital's urban or rural classification. The same diagnosis triggers two payment schedules on the basis of the hospital's location. There is no consideration for hospitals located near urban areas that must compete for the same services, personnel, and wages, just to cite a few examples. The Medicare reimbursement system does not account for those costs that are beyond the control of the hospital.

One such hospital that is surrounded by urban areas is Memorial Hospital in Owosso, MI, in my district. The administrators of the hospital estimate that under the current Medicare prospective payment system, Memorial Hospital will lose approximately $1 million in 1987. The hospital must absorb any costs that are over and above those fixed Medicare payments. The results of absorbing those excessive costs for the same services granted as those in urban areas, but reimbursed at a lower level, will be devastating to Memorial Hospital.

Memorial Hospital will thus become a victim of the Medicare prospective payment system unless the urban-rural classification is changed.

The urban-rural designation must take into account the regional variations among the rural hospitals. Many rural hospitals pay more for goods and services labor, transportation, and supplies due their locale. Yet reimbursement does not permit consideration of those hospital specific factors.

The Secretary of the Department of Health and Human Services, Margaret Heckler, has promised Congress an updated revision of the area wage indices. The area wage indices are an integral part of the reimbursement formula for the DRG's. Congress is waiting for those new indices. Rural hospitals are waiting for those new indices.

The revision of the area wage indices would provide a good basis for the long term overhaul of the Medicare prospective payment system. It would be a start, but there are many other necessary changes that must occur so that an equitable reimbursement system may prevail. How long can the rural hospitals wait? We have been waiting for the changes in the area wage indices. How long must we wait at the expense of the elderly Medicare patients? Health care services are at risk while we wait for the HHS revisions. It is intolerable that the present system provides incentives for the rural hospitals to cut corners and potentially reduce the quality of health services by withholding sufficient Medicare reimbursements.

I know that Memorial Hospital is not the only rural hospital that will be unable to survive such an enormous shortfall of funds. We must persist in our efforts to obtain changes from HHS in the Medicare prospective payment system.

HOUSE OF REPRESENTATIVES,
Washington, DC, May 7, 1985.

Hon. FORTNEY H. STARK,
Chairman, Ways and Means Subcommittee on Health, Longworth House Office Building, Washington, DC.

DEAR PETE: I am writing to tell you about a meeting I recently had with hospital administrators in Northern Iowa to discuss the inequities of the current urban/rural area wage index and the recent HHS wage index report submitted to Congress.

This April 20th meeting generated a stimulated discussion of the desparate situation many of my rural hospitals are in because of the inequity of the wage index, and our goal was to reach a consensus with regard to the March 29th HHS report. Most specifically we discussed the two wage indexes (gross and adjusted gross) described in the report, and whether retroactivity was an issue on which they could compromise. Just for your further information, you will be interested to know that my rural hospital would gain under the new wage indexes, although in much more limited way that had been anticipated. My two urban hospitals in Sioux City would loose under the new wage indexes in a larger way than had been anticipated.

As you can probably guess, it was agreed that the new wage indexes are definitely more equitable than the current wage index, and the adjusted gross wage index is the more preferable of the two. However, what you may be surprised to learn is that this group of hospital administrators is willing to accept the elimination of the retroactivity provision if that is the compromise necessary to enact one of the new wage indexes as soon as possible.

Having reviewed the report thoroughly, I am well aware of the far reaching implications of the new wage indexes described in the report, especially if retroactivity is not eliminated. At this juncture I believe two facts stand apart from other concerns: (1) Before the report there was near unanimous agreement that the current wage index treated rural hospitals unfairly; and (2) the calculation and data used to devise the new wage indexes is obviously more fair (although still lacking in addressing important differences). For these reasons, I urge your prompt consideration of legislation to implement the new adjusted gross wage index with the elimination of retroactivity.

I appreciate your time and consideration of this matter. If I can provide you with any additional information about hospital conditions in my district, please do not hesitate to contact me.

With best regards, I am
Sincerely,

BERKLEY BEDELL.

Mr. **DAUB**. Congress has recognized by evidence in the record shortcomings in the current index and required that the Secretary of HHS report revised indices within 30 days of the enactment of the Deficit Reduction Act passed last summer. Unfortunately, compilation of the hospital data needed to devise this new wage index has proved to be more complicated than originally expected. A final report was not received until March of this year.

I would indicate to the committee that I have drafted legislation, if we have to use it. I think that I am prepared to move in a prospective way, if I might use the term, Dr. Davis, that is to say to implement, if we can, the June proposed regulations as of October 1, without the retroactive feature. This has the support of both a substantial number of our colleagues and hospitals in their districts. I think that is a fair compromise.

So let me ask you this set of questions. Secretary Heckler sent to Congress the report that listed two alternative wage indexes. Are both of them better than the Bureau of Labor Statistics index currently being used, in your opinion?

Ms. **DAVIS**. Well, I think there are different opinions as to what index is the most appropriate. Clearly, we spoke to both a gross and adjusted gross, looking at those as having the ability to identify the difference between part-time and full-time benefits. Our belief is that that clearly is a useful index. We did work very hard to come back and have the material audited so that we could feel as confident as we could with the data. Just like anything, there are probably minor flaws in it, as with any type of collected data. You rely upon the sources to collect it.

Mr. **DAUB**. Which of the two indexes, gross or adjusted gross, would the department prefer?

Ms. **DAVIS**. I think there could be valid reasons for either one, but we think that probably the gross might have a little less ability to have the individual entities within it have reporting errors. So I think we would probably favor the gross over adjusted gross.

Mr. **DAUB**. Is it just less complicated from an administrative point of view?

Ms. **DAVIS**. Yes.

Mr. **Daub**. Would the administration oppose implementation of a new wage index for fiscal year 1986?

Ms. **Davis**. Right now we have a statute that indicates if we are to implement it, we must implement it retroactively. Until that requirement is removed, we would have to continue forward on that track.

Mr. **Daub**. What are the arguments, if you know of them, opposing implementation of this new wage index, the gross wage index?

Ms. **Davis**. I think the only thing that I have——

Mr. **Daub**. Is there an argument, that it fails to account for fringe benefits for hospital employees, for example?

Ms. **Davis**. I have heard that, yes, that we did not ask for the fringe benefits in our——

Mr. **Daub**. Do BLS standards take that into account in other areas?

Ms. **Davis**. No, they do not.

Mr. **Daub**. Why would that objection then be necessarily attached only to thwarting an effort to implement the new adjusted gross wage index?

Mr. **Booth**. I think the answer, Mr. Daub, is that both of the HCFA wage indices, as presented, tend to advantage hospitals in rural areas. The counter-argument being advanced is that since the fringe benefits would accrue to full-time workers more than part-time workers, that the swing has now gone more than half way. I don't know, you can make your own judgment about that argument. I believe that is the argument they have advanced.

Mr. **Daub**. How would the revised index be updated, Dr. Davis?

Ms. **Davis**. We have not thought forward in that particular area. When we did this particular study, it was done as a one-time effort. I will say that because we didn't have any law that mandated that collection of data, it was extremely difficult to retrieve all of that data. I would suspect if we had to do it on an annual basis, we would have to have legislation that would require some type of report so that we could obtain it.

Mr. **Daub**. Could the survey used in formulating the gross adjusted gross index, whichever we use, be attached to the annual cost report and used by HCFA to annually update the index?

Mr. **Booth**. Mr. Daub, I would think that is certainly possible. We could ask. Unfortunately, as you and I think some other members of the committee are aware, we are a little late in getting the data in and available. It would be a question of how long we would want to wait to have that data. The current survey was dependent upon the audited cost data from 1982. One option certainly is to use the cost——

Mr. **Daub**. The auditors are going to testify later. I intend to ask them some questions about all of these things as well. I appreciate that.

Mr. Chairman, all I would say, in concluding, is that I really believe we know enough now from the reports that had Congress acted last year and said "Put a new index in effect," even the losers would have agreed that is fair. It is budget neutral. We do have this report, I might point out to my colleagues, which I think everyone does agree can be used as the basis for acting in this area, particularly if we can agree on the retroactivity portion. Getting retroactive payment would be a difficult prospect.

I want to thank Dr. Davis for working on the report.

Chairman STARK. I appreciate the gentleman's interest. I am sure the committee will address its concerns appropriately.

Mr. Gregg.

Mr. GREGG. I have no questions. Thank you.

Chairman STARK. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman. Thank you.

Dr. Davis, did I understand that you are prepared to file your report on your plan for the capital prospective payments in 30 days?

Ms. DAVIS. No, sir, I don't think I spoke to when the Department plans on coming forward with the report on capital payment. I, myself, have been so terribly involved in about 40 other reports to Congress that I have not really tried to track the departmental effort as closely in the capital area, since it is one of the few for which I don't have responsibility.

Mr. DUNCAN. You don't dare make a guess as to when it might be?

Ms. DAVIS. I think it would be inappropriate to guess as to when. I know they are very interested in it and working hard on the particular report.

Mr. DUNCAN. May I say you have been sort of chastised for being late on the report, but no one is a worse violator of filing reports, or adopting budgets, than the House of Representatives. We made studies and held hearings 15 years ago on things we haven't filed a report. [Laughter.]

Thank you, Mr. Chairman.

Chairman STARK. Chivalry certainly isn't dead in Tennessee. [Laughter.]

Dr. Davis, if you will indulge me just a bit longer. The American Hospital Association has requested that if we freeze the DRG payments we should guarantee that hospitals be paid no less on a per case basis in 1986 versus 1985. Do you or your associates know what the budget impact of this would be? Do you understand?

Ms. DAVIS. I don't think we do. One of the problems would be that we would have to keep the case mix exactly the same as it is right now. That from my observation has been moving.

Chairman STARK. That would lead to my next question. The case index has increased fairly dramatically.

Ms. DAVIS. Yes, it has.

Chairman STARK. The past couple of years. My suspicion is that it may be just hospitals cheating, or a nicer way to say it is DRG creep. But do you have an opinion on why the case mix has changed so dramatically?

Ms. DAVIS. We had anticipated some changes as a result of better coding. We tried to adjust for the better coding. It may well be we didn't adjust enough. It may also be that those little black boxes being sold to help to uncode are working. We have been trying to buy them, keep ahead of the market but it's a little difficult to do it.

Chairman STARK. Will you share with us now what your regulations intend to do about this rate creep.

Ms. DAVIS. Obviously one of the things we have been charged with is keeping the system in correct balance. We will take into account productivity. We will take into account case mix activities that have been occurring when we——

Chairman STARK. You are going to try to beat us to the punch, aren't you? You are going to have those out by June 1?

Ms. DAVIS. June 3.

Chairman STARK. What if we change them by legislation? Is that going to be confusing for the hospitals?

Ms. DAVIS. If you change the legislation?

Chairman STARK. If we change your regulations by legislation, subsequently that will be a little confusing for the hospitals, won't it?

Ms. DAVIS. Oh, I think they are adaptable.

Chairman STARK. Wouldn't it be a better idea to share some of those regulations with us and see whether we might compromise on some if the committee had differing opinions?

Ms. DAVIS. I have a law that tells me I am supposed to have those regulations out by June 3.

Chairman STARK. You have a law that tells you you should have had a report to me last October 1984. Same law really.

Ms. DAVIS. I know.

Chairman STARK. Is there a law that says you can freeze rates?

Ms. DAVIS. No, sir, but it does leave up to the Secretary the discretion and asks in fiscal year 1986 that she take into account activities such as productivity, case mix increases and a variety of other factors.

Chairman STARK. What are the other factors that she should take into account before she freezes rates? I think those are comprehensive, if—is there a list of what she must take into account?

Ms. DAVIS. I think the legislation itself reads that she is asked to take into account productivity increases.

Chairman STARK. Yes.

Ms. DAVIS. Case mix and effectiveness and efficiency of operations.

Chairman STARK. Do you have that information available now?

Ms. DAVIS. We have information as it relates to what we perceive to be productivity and case mix increases.

Chairman STARK. Case mix.

Ms. DAVIS. Case mix.

Chairman STARK. Do you have that in sufficient detail to allow you to make regulations?

Ms. DAVIS. We believe we do, yes.

Chairman STARK. But not sufficient detail to complete the reports the committee asked for?

Ms. DAVIS. Well, the reports are much more specific because they are related to specific areas. Such activities as the uncompensated care, the disproportionate——

Chairman STARK. Would it be fair to say that you have information to make decisions you want to make but you don't have any information to give to this committee if we wish to legislate? Isn't that really the system that you are operating under?

Ms. DAVIS. No, it is not.

Chairman STARK. It would appear to the uninitiated, that is me, that that is exactly what is happening. I don't like really to ever, you know, not to make threats. But the reason I am concerned about this is that, again, I think that this committee will probably pass some legislation.

And I think you, Mrs. Heckler or Mr. Stockman are following the course of presuming that if we don't have information we can't legislate. I would say to you that that would have disastrous results for the citizens of this country who depend on medicare, and it's going to be your fault.

It's going to be the administration's fault because I think you have the information and you are hiding it because I think you know the results and it's going to look bad for Stockman's budget when they come out.

And to cheat poor elderly people out of medical care, which is what I think your department is doing, is a sin. It's a crime. It's an obscenity. And I am just going to tell you, I am warning you. The committee is going to respond to what people need, and you are just not playing fair with us.

I am troubled. I am sure you are too because I am afraid it isn't your fault. I think you are a very nice person, and I think you are being gamed by some mindless budget balancer. I think that is sad. I would like to ask Mr. Dobson, you are a professional research person; is that correct?

Mr. DOBSON. Yes, sir.

Chairman STARK. What data exists from which we could determine which hospitals might have a disproportionate share of poor people?

Mr. DOBSON. As Dr. Davis noted we have been working on that for a couple of years. We started with the assumption that our administrative statistics do not carry information aside from patients age, sex, race, and location of service.

To go beyond our administrative data which we had to do to get information on disproportionate share, we started with a survey conducted I believe in 1981—a 2-week survey done by the Office of Civil Rights.

That survey had some indication of poverty variables and, in particular, it had the percent Medicaid variable. We took that percent Medicaid variable and did our analyses from it. We used that data as have other researchers; there are four or five research teams working on the project, as you probably know. We all used essentially the same data and we found essentially the same results.

Unfortunately, when we looked at the data much more carefully we decided the percent Medicaid data collected in a 2-week survey primarily done for other purposes was not adequate for something as important as this. Then when we looked around we decided there was an alternative data set we felt would probably be better, more comprehensive, and representative of an entire year's worth of activity as opposed to 2 weeks. That is the data Dr. Davis referred to.

Chairman STARK. Is that still based on Medicaid——

Mr. DOBSON. That will be percent Medicaid and percent Medicare as well.

Chairman STARK. Do you have in mind a threshold level?

I gather what you are saying is that if the income of a hospital, gross income, is a certain percent Medicaid payments, that is a fair indication that that hospital has a high proportion of poor people?

Ms. DAVIS. Yes, we could use——

Chairman STARK. If it's 100 percent Medicaid payments one would say that is a lot of poor folks, right?

Mr. DOBSON. That is right.

Chairman STARK. How far down the scale do you come before you say, well that is just the population break?

Mr. DOBSON. I think we should let the data describe that. We can divide the data into categories, zero to 10 percent, 10 to 20, 20 to 30, et cetera. Essentially we can provide a threshold.

Chairman STARK. What is the——

Mr. DOBSON. The average in the country is 11 percent. I suspect we wouldn't want to pay the average. I would think bigger than 11 percent, certainly lower than 80 percent because there are only two or three hospitals in the country that have that. Somewhere between 20 and 80 percent. I realize that is a large range, but——

Chairman STARK. I understand that. Can you give me the cost? It's obvious that if we use 80 percent we are only going to scrape a few hospitals.

Mr. DOBSON. That is right, three or four or five.

Chairman STARK. But we know what that is going to cost. There are only 600, 700-some odd hospitals in the population, I think that is what the American Hospital Association will testify, over 20 percent I think, 628 hospitals——

Mr. DOBSON. We are not altogether sure we would agree with their list but there would be some number——

Chairman STARK. Over a thousand? Give me a maximum number again.

Mr. DOBSON. Under a thousand, maybe.

Chairman STARK. So we could build just to see OMB, a model that would say if we take 80 percent, this is the cost, if we go right down the list of a thousand we can add up the costs as we go further down the list, right?

Mr. DOBSON. The first thing we have to do is determine if there is a relationship between percent Medicaid and Medicare allowable costs. Then we will try to determine how sensitive that relationship is as the percent Medicaid increases. If there is no relationship then, I don't think——

Chairman STARK. Do your data show that already?

Mr. DOBSON. We have noted a preliminary relationship with the data we have. We have so noted that to staff.

Chairman STARK. Let me put it to you another way. Let's just say that this committee, with its lack of information, was going to make the decision that if a hospital serves a large number of poor people it is entitled to, say, 10 percent higher payments.

We may be forced to just to pick a number in the absence of any other data. Is there any other way you know of, any other set of data for us to use to identify those hospitals? We may pay some too much, some too little. Let's just say we are going to use *x* number of bucks. Are there any other statistics we could measure other than percent Medicaid?

Mr. DOBSON. Dr. Davis mentioned one series of statistics we are investigating, a longer run scenario whereby we are going to look at percent poverty by zip code. We will link percent poverty by zip code. We will then link percent of patients that come from poverty zip codes to a given hospital.

We can add them up zip code by zip code and then give an indication that, say, a given hospital draws its patients—particulary those over 65—and proportion of poverty over 65—from those zip codes. Then we can do essentially the same things we will do with the percent Medicaid population variable. We will have the percent of patients drawn from poverty zip codes where we can use the census definition of poverty. That would be a new source of data.

Chairman STARK. Would another source not be, I gather the hospitals are reluctant to do this but given enough incentive dollars, they might. The hospitals have this fear don't they? They generally have financial information about patients they admit?

Mr. DOBSON. There is an annual survey by AHA that has those sorts of information. On the other hand, when the survey is conducted as with most surveys there are very stringent confidentiality requirements and the hospitals are rather reluctant to share that and AHA is rather reluctant——

Chairman STARK. It's my understanding hospitals may share that with us if we take it to closed session. Would you like to attend?

Mr. DOBSON. I believe that is up to my——

Chairman STARK. You are not even curious?

Mr. DOBSON. Oh, I——

Chairman STARK. Again, I just want to suggest to you that it is a matter of some concern. I think bipartisan concern. It is a step we can take legislatively, if that is what we must do. I would think it's going to happen. Therefore, I again put the burden on you all, you know it. I think the information is there.

My feeling is if you have information to write regulations, to freeze rates—you must also have the information to help this committee. To stonewall us seems to me puts, tension which is good, between budget and government, lack of communication I think only leads to contention. That is apt to have sad results. So there is tremendous pressure on us to do this. I just wish we could do it together.

Dr. Davis.

Ms. DAVIS. Mr. Chairman, I would just like to clarify one thing. That is the data we have in relationship to writing the regulation is related to the aggregate data on productivity and case mix increases. It does not have anything to do with the disproportionate share issue. That is a separate issue and we are working very aggressively on getting that data.

I think I will have to respectfully take issue with you that I believe we are doing the very best job we can and we are being cognizant of the needs of the elderly as we move forward in this particular area.

I believe later on you will hear from some individuals that perceive our rates may already be overpayment. We hear most of the time that they are underpayments. So you put the two together, it must mean the rates we are paying are approximately where they should be.

But we do need to continue to make refinements in the system and we are pledged to do that.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Dr. Davis, I regret I had to leave the committee for a moment. I know you talked about this disproportionate share problem. As I understand it you have indicated there may be some way to define a severe illness, and you think perhaps you ought to have a study. I want to ask you again. If you took that approach when would you have a report ready for this committee?

Ms. **Davis**. There are separate reports. The one I think you are referring to, Mr. Pickle, in relationship to the severity of illness index is one due in December 1985.

Although we have done some preliminary work and in fact our recent issue of the Health Care Financing Review does contain a discussion of about five of the different severity of illness indexes we have been doing——

Mr. **Pickle**. Had you not indicated to someone you might have a report or study completed sometime in June on this question?

Ms. **Davis**. I am sorry. That is in relationship to the disproportionate share.

Mr. **Pickle**. Yes.

Ms. **Davis**. Yes.

Mr. **Pickle**. So within the month of June you hope to have a collection, make a report to our committee on that one subject?

Ms. **Davis**. On that one subject.

Mr. **Pickle**. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Rangel.

Mr. **Rangel**. Thank you, Mr. Chairman.

Mr. Dobson, you are director of the Office of Research?

Mr. **Dobson**. Yes, sir.

Mr. **Rangel**. Now, do you have any difficulty in finding out whether we have medically underserved communities?

Mr. **Dobson**. I personally am not involved in the study of medically underserved communities. That is primarily a function of the Public Health Service.

Mr. **Rangel**. Would you know where to find out where the public hospitals were, the hospitals that are operated by cities and counties and States?

Mr. **Dobson**. We have done that already.

Mr. **Rangel**. Do you know where they are?

Mr. **Dobson**. Yes, they are coded on our Medicare system.

Mr. **Rangel**. Do you have access to census tracts which would show where the poor are living?

Mr. **Dobson**. We are currently pushing zip code data, more refined than census tract—ZIP code data is what we are trying to get a hold of.

Mr. **Rangel**. But you had the census data before you decided you wanted the zip code? You could really decide every 10 years where the poor were supposed to be, right?

Mr. **Dobson**. That is true.

Mr. **Rangel**. If you got together with Mr. Booth from the Office of Reimbursement he also could share with you where the Medicare patients were going, so you could almost see whether there was a target or an area—you can't do that?

Mr. **Booth**. No, Mr. Rangel, you can't. The problem is that while there is a data element request in the Medicare cost report, for Medicaid data, 65 to 70 percent of the providers do not fill that out because it is not required for Medicare reimbursement and we do not audit it.

Mr. **Rangel**. So he would have no way of knowing which communities were receiving the percentage of Medicaid and Medicare reimbursement?

Mr. **Booth**. Not from the data I have.

Mr. **Rangel**. This urban institute, do you know who they are?

Mr. **Booth**. Yes, I do.

Mr. **Rangel**. Who are they?

Mr. **Dobson**. A group of researchers located in the city. They have a staff of economists and other sorts of professionals.

Mr. **Rangel**. They claim they have come up with this information. Have you had a chance to review it?

Mr. **Dobson**. They have information on disproportionate—I am sorry, uncompensated care that they have worked with for some time now. They have done some fairly detailed analysis of the magnitude of uncompensated care, which hospitals, et cetera, and interestingly enough typically they find the Medicare, Medicaid payments aren't necessarily related with uncompensated care.

In fact, they find that perhaps Medicare and Medicaid tend to cover their patients fairly well and that the hospitals with high proportion of Medicare and Medicaid payments aren't necessarily those with high proportions of bad debt and charity.

Mr. **Rangel**. How about the Congressional Budget Office, do they have any information that indicate how high Medicaid costs are in relationship to serving low-income patients.

Mr. **Dobson**. I believe when they did an analysis comparable to ours they found percentage Medicare was not related to Medicare allowable costs, as we found as well. I believe on the Medicaid side they found some relationship between percent Medicaid and Medicare allowable costs. But, again, they use the same data we did. It was very uncertain data.

Mr. **Rangel**. But in the course of your research you found no relationship, for example, between the severity of illness and the low income of the patients?

Mr. **Dobson**. We have not specifically looked at the severity of illness and low income patient at HCFA. We did do something with the public hospitals where we tried to ascertain whether length of stay and case mix were significantly different than other hospitals. What we found was we could not, with our administrative statistics, determine that the public general hospitals had sicker patients in terms of length of stay and in terms of DRG mix than other similarly situated hospitals.

Mr. **Rangel**. My public hospitals tell me that they can't get rid of the patients sometimes because there is just no place to send them.

Mr. **Dobson**. It may be that our data, our data was 1981 cost report data—does not reflect that the situation has changed since then. We have certainly discussed this a great deal with the public general hospital industry and have puzzled a lot about our findings with them.

Mr. **Rangel**. Dr. Davis, when we get this information will we receive it in time for you to make the regulations apply if there is any changes that would be recommended by June 1? Is that the date your office normally has as the deadline for the regulation?

Ms. **Davis**. We would not have the material in relationship to disproportionate share in time for June 1. We will not have that until the end of June. It would be possible to consider that in the final regulation. Our general counsel might feel we would have to do it as an interim final to allow more time for comments or perhaps another way we could put something out in the interim. But generally speaking we go out with a proposal and wait for comments and adjust it.

Mr. **Rangel**. I am trying to find out just how much delay would be involved if we missed the June 1 deadline, and your data is prepared in June, then when would we be able to use the information, if adjustments were necessary?

Ms. **Davis**. I don't know, Mr. Rangel. What I was trying to say is, it is possible one might be able to do an adjustment by this October. But again it is the type of thing that until we see what comes out of the data base I couldn't say for certain.

I was speaking to the fact that the proposal for next year would already be out and that if we did do an adjustment we would have to think of some way to do it that would make it appropriate in a final regulation when we would not have had the opportunity to have it out for comment. That is part of the problem.

Mr. **Rangel**. Are you saying it would be necessary to make those adjustments even if the information is later for next year?

Ms. **Davis**. No, I am saying if one wanted to make those for next year, I am trying to think through how he could do it in the formal and the normal legal process we follow. Our administrative procedures guidelines require we publish something, allow comment time and then implement at a final point. Because of our time deadlines we already will have the proposal for next year out in early June, June 3.

Mr. **Rangel**. There is no way to amend it?

Ms. **Davis**. I don't know. I am not a lawyer. I would have to ask my legal staff for advice on that part of it. There may be a way. I don't know for sure.

I would like to make one or two comments.

New York is a waiver State. We have been hearing predominantly from your hospitals in your area, it may be related to some of the issues going on within that State. It's not within the prospective——

Mr. **Rangel**. I know we have a waiver. But there are certain things that happen in low income communities that really have nothing to do except with expenses. I am talking about well patients that are old that have no home, no family, no social workers, no nursing homes. And the public hospital directors just don't put them in the street as they are required to do by law. And when I was going around these inner-cities it was not a new problem.

The more affluent hospitals just put them in an ambulance and take them to a public hospital. Now that was the public record.

And this is as a very expensive thing to have old folks just sitting around with all those doctors and nurses when they don't need them.

Then they talk about the complications that are necessary, that old folks need more nurses. I don't know. I just thought in talking with my sister who, like you, is a nurse, that this was a common fact. That old folks just complain more, they have more pain. And you have to be around them more. But I guess that is not so.

Ms. DAVIS. I think our analysis a couple of years ago in the Department would indicate that there was a necessary need for a differential payment for nursing services. As you may recall 2 or 3 years ago we did away with recognition of the nursing differential because the data didn't find there was a difference in relationship to the burden of care. It really deals more with the severity of illness an individual has than with age level.

Mr. RANGEL. In that case we were talking about the aged only. But I assumed the same was concerned with the poor that would come in with more complicated illnesses.

Ms. DAVIS. That is what we are trying to find out.

Mr. RANGEL. OK.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I had a colloquy earlier with Mr. Matsui and indicated I wanted to ask you a couple of questions. Allow me just a couple of minutes to proceed along those lines with reference to the transition.

Which geographic region of the country would be most disadvantaged by moving ahead with the transition date?

Ms. DAVIS. I am not certain——

Mr. PICKLE. Would any be disadvantaged?

Ms. DAVIS. I think our preliminary look at productivity measures we have seen around the country would indicate to us that the west, north-central seems to be one of the areas. Again, we have measures that are looking, but as reported, in Hospital magazine——

Mr. PICKLE. Could you give to us a list of those regions, areas you would classify, or hospitals you would classify as disadvantaged? Would you do that?

Mr. BOOTH. You mean with respect to the transition, sir?

Mr. PICKLE. Yes.

Mr. BOOTH. Well——

Mr. PICKLE. Not now but——

Mr. BOOTH. The measures are relatively crude. One of the problems is that there are significant differences within the regions themselves.

Mr. PICKLE. Tell me then what regions are, or individual region would be more disadvantaged than other regions?

Mr. BOOTH. Based on our preliminary data, the region who would do best by freezing the transition would be the west south-central region which does include Texas, sir.

Mr. PICKLE. You answered in reverse. [Laughter.]

I wanted you to—did you do that for a purpose? [Laughter.]

I am seriously trying to find out what regions are disadvantaged, why are they disadvantaged, and what do you mean when you say they are disadvantaged? Can you give me that kind of response? What do you mean when you say a hospital is disadvantaged?

Mr. **Booth**. You have to look at the impact of moving from hospital-specific rates to the national rates and from the regional rates to the national rates to understand on an individual hospital basis whether a hospital does better by moving ahead with the transition or by stopping where it is.

So there are two factors that you have to consider. One is the hospital-specific rate against the Federal rate, and the other is the regional rate against the Federal——

Mr. **Pickle**. I understand that. But you either have a national rate or you don't. So you just can't cut the pie up in 20 different pieces. You either have a national rate or you don't. I am saying if you delay it, on what basis do you delay it?

American Hospital Association made a survey, you can say that is a substantative and reliable survey, which showed all the hospitals basically are doing better for the first time in 20 years. Some may not be making as much profit. But they all apparently are doing better, almost all.

If that is a fact, when you say disadvantaged that doesn't mean they are losing right and left, but rather they are not maybe doing as well as others. If that is so, why don't you go ahead with the national rate?

Mr. **Booth**. That is precisely what we intend to do, sir.

Mr. **Pickle**. Fine, Mr. Chairman. I yield the balance of my time.

Ms. **Davis**. I think what we were trying to refer to is that we have seen there has been a dramatic reduction in the length of stay, some reduction in the number of ancillary services being used. There is differential across the country. We believe that we really should continue to move toward the national rate because from everything we can see it does appear there would not be any one reason why any one region would be significantly adversely impacted.

A part of our wanting to move to a national payment system was because there were such significant swings around the country in payment for the same kind of procedure that we felt it——

Mr. **Pickle**. Thank you.

Chairman **Stark**. I gather Illinois and California get hit the hardest as we move ahead on the change. Why is California so much more expensive? Why does it cost twice as much to get something removed or transplanted in California than Alabama? Does anybody have an opinion?

Ms. **Davis**. I don't think we know for certain.

Chairman **Stark**. It can't all be wages, can it?

Ms. **Davis**. No, sir. Sometimes it is the stacking patterns. We would have to look to see. Stacking ratios have some degree or relationship to what the cost per case is. Although we have noticed cost per case has been dropping.

Chairman **Stark**. If you all would be willing to respond to written questions, some of which we still have remaining.

Mr. **Rangel**. Mr. Chairman, may I inquire, as to New York State, they have the Medicare waiver which expires this year. Until you become permanent would that be an automatic extension of the waiver?

Ms. DAVIS. No, sir, they must file for that. At this time the waiver is a time-specific waiver and in talking with the people from the State I don't think they have made up their mind whether they want to file for another waiver or not. They are still sorting that out within the State.

Mr. RANGEL. Thank you.

Chairman STARK. So I have asked you if you are willing to respond to questions from the staff.

Thank you very much, and Mr. Booth and Mr. Dobson, thank you.

I would like to announce to anybody that is interested in the audience, it is the Chair's intention to continue these hearings through lunch and if any of you are hanging on the edge of your seats or next up, it will be of no concern to the Chair if you want to bring food or drink into the room. Just don't chew with your mouth open. [Laughter.]

We will be interrupted from time to time, I am afraid, by votes. It's my hope the Members will kind of stagger running back and forth to record their preferences and that we will not have to recess during the votes.

I notice Mr. Porter is here now. Mr. Porter, we will be glad to take your testimony now.

STATEMENT OF HON. JOHN EDWARD PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. PORTER. Thank you, Mr. Chairman.

Mr. Chairman, thank you for the opportunity to testify before your subcommittee this morning.

I am appearing here today to call attention to a situation that needs correction by the Congress. I have learned that many hospitals, including hospitals in Illinois, will incur substantial financial losses as the prospective payment system [PPS] implementation moves to the next phase and the full national reimbursement rate is implemented on October 1, 1986. I am suggesting that instead the process be frozen at the current level, 50 percent hospital-specific and 50 percent Federal DRG rate, until HCFA completes its study of the national rate impact on hospitals across the country. The Illinois Hospital Association will testify today to present its specific concerns to you. Let me briefly outline my view of the problem.

We are now well into the second year of operating under PPS. Hospitals are reimbursed at a rate which is a blend of 50 percent hospital-specific costs and 50 percent Federal DRG—25 percent national and 75 percent regional—rates. According to the implementation schedule, effective October 1, 1985, hospitals across the country will have their rates adjusted to reflect 25 percent hospital-specific costs and 75 percent Federal DRG—50 percent national and 50 percent regional—rates. Finally, effective October 1, 1986, 100 percent of the payment will be determined under the national DRG methodology. The national rate is the problem.

When Congress discussed the original PPS proposals, it recognized the tremendous redistributions a national rate would cause. So a 3-year phase-in period was provided for to allow providers to adjust. The phase-in, however, does not alleviate the inequities a national rate creates. It does not recognize the regional cost differences that exist from one part of the country to another. Urban hospital costs varied 20 percent from the lowest regional rate to the highest, and rural hospitals varied 16 percent. It is obvious then why there exists a great deal of concern about the continued transition to a national rate.

Combining the rural and urban components of each State's Medicare reimbursement and examining them from a total revenue perspective, a move to national rates redistributes Medicare funds from 17 "loser" States to 26 "winner" States. Illinois, Michigan, California, and Ohio are among the 5 top "loser" States. I might add, Mr. Chairman, those 5 top loser States, in fact those 17 loser States, have a tremendous number of votes in the House of Representatives. A national rate does not save any Federal dollars. All it does is redistribute the funds the Federal Government spends for Medicare beneficiaries.

Mr. Chairman, even without a sophisticated analysis, it is obvious that the impact of a national DRG rate on many States will be significant. In one example, in my State of Illinois where costs are higher than in many other areas of the country, it will be catastrophic. A reimbursement rate set at the national norm is estimated to reduce Illinois hospitals' Medicare funding allocation approximately $100 million by the end of the current fiscal year and $200 million beginning October 1, 1986, when the full national rate is scheduled to be implemented. These losses will become windfalls in States which have costs below the norm.

To give you an example of why I think the PPS reimbursement rates should be frozen at current levels, here are several key statistics from my State of Illinois:

Eighty-two percent of the population lives in urban areas, which is 30 percent more than the national average.

There is 27 percent more unemployment in Illinois than the national average.

There are 11 percent fewer college educated people and 4 percent fewer high school educated people relative to the total population in Illinois compared to the national average.

Illinois has 6 percent higher energy expenses.

Illinois has 3 percent more unionized employees.

Illinois has above-average construction costs.

And, as you can well expect, the hospitals in Illinois are also not average. The following are important considerations:

Illinois hospitals' bad debt, charity care and unfunded Medicaid service is 22 percent higher than the national average.

Illinois hospitals' profitability is 10.3 percent below the national average.

Illinois hospitals' gross revenue is depressed by 39 percent higher than average deductions resulting from arrangements with third-party payers, such as Medicare.

Illinois hospitals have 15 percent more reliance on operating revenue from sources other than patient charges to ensure their financial stability.

Mr. Chairman, the Illinois example shows how important it is to freeze PPS reimbursement to all hospitals at the current levels.

This situation is disturbing since it seems inequitable that hospitals in some geographic regions will benefit to the detriment of hospitals in other regions.

I am confident that you may hear testimony today from those who would like to have the blend continue to proceed as the statute requires. However, under a formula where there are 17 "loser" States and 26 "winner" States, this is to no one's surprise.

This brings me to the issue of cost-cutting by the "loser" States. Mr. Chairman, HCFA has responded that "phasing in a national rate over 3 years, the impact on hospitals with greater than average costs would be minimized * * * (and would) allow hospitals to take cost-cutting measures in anticipation of a fully national Federal rate." This rationale assumes that hospitals in higher cost areas of the country, such as Illinois, will be able to simply cut costs over a period of time and absorb the impact of a national rate. Illinois hospitals would be expected to reduce costs $200 million to $350 million per year—without going bankrupt or eliminating essential services. This rational is seriously flawed.

Hospitals in my State have responded positively to PPS. They have cut costs at every opportunity in response to the dramatically changing health care delivery system of which they are a part. Admission rates and lengths of stay are down; the use of less-costly outpatient settings is up. More than 11,000 jobs in Illinois hospitals have been eliminated in the last 18 months.

Statewide in 1984, Illinois hospitals kept the average expense per admission—that is, the cost to the patient to be treated for an episode of illiness—to an increase of less than 3.9 percent. That is less than the Consumer Price Index rise in 1984; it is a phenomenal achievement for the Illinois hospitals.

Finally, we need to recognize that PPS is still in many ways an experimental system. We are well into the second year of the system. Congress recognized at the outset that adjustments would need to be made as the system was implemented and became operational. Congress has required HCFA to prepare several reports which analyze and evaluate several key aspects of the system, including studying regional cost differences and reporting the reasons for such to Congress by September 1, 1984. Unfortunately, as of this date, the report has not been issued.

Prudence dictates that we act responsibly to avoid becoming trapped in a situation which could have devastating results on the quality of health care delivered in this country and seriously curtail the availability of needed service to our Nation's elderly. I strongly urge this committee and the Congress to adopt legislation which will freeze further movement to a national DRG rate until it has had an opportunity to study and consider the special study which HCFA is completing. Such action will not adversely affect the Federal deficit since PPS is budget neutral. This grace period will permit time to develop any necessary corrective legislation to ensure this gross inequity is eliminated.

I thank the committee for its kind attention. I will be happy to respond to any questions you may have.

Chairman STARK. John, thank you. I share your concern, but I want to repeat what I said to my colleague, Mr. Matsui, that I can't understand why 50-50 is any better than 75-25 or 25-75. You say 17 States lose. That means we have 33 States that win.

Mr. **Porter**. Twenty-six that win, Mr. Chairman.

Chairman **Stark**. I have trouble understanding why, for instance, Illinois loses—according to testimony we will get in a while—$77 million, goes down 3½ percent. Pennsylvania, on the other hand, picks up $36 million and goes up a percent and a half. Both have famous medical colleges in them, both have urban and rural areas.

Until we can explain that to ourselves, why should we go ahead and find out why that difference is?

Mr. **Porter**. I think you have answered the question yourself, Mr. Chairman. You have said until we can explain it to ourselves. We can't explain it to ourselves. We are awaiting studies that will explain it to ourselves. If we allow the process to continue, Illinois is already $78 million out of pocket. At the end of next year, it will lose another $100 million, and at the end of fiscal year 1987, it will lose $200 million. The damage will have occurred, Mr. Chairman, by the time you get the study unless you delay the transition until the data is available.

Chairman **Stark**. What about Tennessee that is looking to pick up $28 million they may have felt they saved last year?

Mr. **Porter**. Mr. Chairman, picking up is one thing, but losing is another. You will have hospitals in bankruptcy that don't deserve to be in bankruptcy while others are getting a windfall they don't deserve to get.

Chairman **Stark**. There has been no evidence of that.

Mr. **Porter**. Mr. Chairman, under the whole system, it is bound to happen. The question is, is it fair to have certain hospitals in certain regions bear the brunt of this while we say we don't know the answer?

Chairman **Stark**. The answer is all we will do is change, you can't have both ends of the teeter-totter in the air at the same time. All we are going to do is change those that get hurt. It would be very nice, from my standpoint and yours, to take it all out of California and not have them lose a nickel, but that means Alabama and Alaska and Arkansas and Colorado and Connecticut and Florida and Georgia and Hawaii and Idaho and Iowa are going to lose.

Now, if we knew why, we could make some rational—I mean, if we are just going to count dollars and votes, OK. We just move the scale up or down until we have enough votes, have plus one on the floor of the House, and that is how we make the decision. But it just seems to me if we keep the hospitals in Illinois angry and in California angry, they may pressure the administration to give us the information to tell us what we need; then we will be able to make a more reasoned, intelligent decision.

Mr. **Porter**. You just had Dr. Carolyne Davis sitting here. Why is the information not forthcoming?

Chairman **Stark**. You would have been the eighth person to ask that question.

Mr. **Porter**. I wasn't here for her testimony. Did she answer the question?

Chairman **Stark**. No. Absolutely.

Mr. **Porter**. Mr. Chairman, it seems, you know California has other benefits. My State, an older industrialized State, is taking it on the chin from every single formula that exists in the Congress today. Here is another. Our hospitals are going to be devastated by this. It seems to me if we can't get the information we need, the answer to your question is let's wait until we get it and not allow the process to continue.

Mr. **Pickle**. Mr. Chairman, if you would yield, I would like the gentleman to give the committee the name of the hospital you think would be devastated.

Mr. **Porter**. I don't have the specific names at this time. I can get them.

Mr. **Pickle**. I would like you to furnish them.

[See letter infra.]

Mr. **Porter**. I will.

Mr. **Pickle**. I would like to see the hospitals. I would like to know why your costs are much higher than other parts of the country. Would you give us a list of those hospitals?

Mr. **Porter**. Yes, I mentioned some of the reasons.

Mr. **Pickle**. Are you saying they will be bankrupt if we went to the national rate?

Mr. **Porter**. I am saying, along with other factors, you are going to take the marginal hospitals in Illinois and probably put a lot of them out of business, whereas other hospitals——

Mr. **Pickle**. I have difficulty believing that would happen, but I would want to be certain of it.

Mr. **Porter**. Jake, you don't believe that you are going to have bankruptcies as a result of putting PPS into place? I think you are.

Mr. **Pickle**. Mr. Porter, if indeed you have a large number of hospitals in Illinois that are going to be bankrupt, we ought to know that. If it just means you will make a little less, that is another matter. If we need to make a study as to why the costs there are much higher, we need to know that too. Give us the list of the hospitals.

Mr. **Porter**. I would be happy to do that.

Chairman **Stark**. Mr. Gradison. Mr. Rangel. Mr. Daub.

Mr. **Daub**. Thank you, Mr. Chairman. Thank you, Mr. Porter, for coming.

Do you know what total reimbursements are now, and how much they would drop——

Mr. **Porter**. I don't have that, Hal.

[The following was subsequently recevied:]

ILLINOIS HOSPITAL ASSOCIATION,
Naperville, IL, May 20, 1985.

Hon. JOHN E. PORTER,
Longworth Office Building, Washington, DC.

DEAR CONGRESSMAN PORTER: On behalf of the Illinois hospitals I would like to express my gratitude for your excellent testimony before the Subcommittee on Health of the House Ways and Means Committee last Tuesday, May 14, 1985. Your testimony was strong and you very firmly expressed key points to help persuade the members of the Subcommittee to halt the blend toward a national rate under the Medicare Prospective Payment System.

In the course of the Committee's questioning, two points arose that required additional clarification. Mr. Rangel inquired what proportion of total reimbursement the $200 million loss represents. Attached you will find a chart which describes that answer. If we were to take the $200 million as a proportion to the hospitals' specific costs, unadjusted by any regional or national factors, it would represent approximately ten percent of the reimbursement for inpatient acute care, namely that reimbursement which is subject to DRG's. If, however, we were to take the $200 million as a proportion of the amount hospitals would be receiving under the 100% national rate formula in year four of the system, the percentage would increase to 11.5%.

Congressman Pickle asked for the names of those hospitals that were going to go bankrupt. Instead of identifying hospitals which will "go bankrupt" per se, perhaps a more credible way to answer that question is to provide Mr. Pickle and the Subcommittee a list of hospitals whose reimbursement is disproportionately attributable to the Medicare Prospective Payment System and would suffer severe hardship if a national rate were to be phased-in. It will take a little time for preparation of this data and to secure necessary releases. But we will forward it to you as soon as possible.

In a few days Congressman Robert Matsui will ask for co-sponsors to H.R. 1953, the bill designed to pause the transition to a national DRG rate until the HHS studies can be completed. We urge you to sign as a co-sponsor to the bill as a continuation of your support to this issue.

It is very gratifying to have a responsive Congressman who has been a friend of the Illinois hospitals over the past several years. We have shared with our membership your testimony and will keep you informed of our publications on your behalf. We appreciate your initiative and concern in this matter and are grateful for your continued support.

Very truly yours,

ROGER A. QUICK,
Executive Vice President and Chief Operating Officer.

Attachment.

ILLINOIS HOSPITAL ASSOCIATION MEDICARE PROSPECTIVE PAYMENT SYSTEM [PPS] PROJECTED IMPACT OF MATHEMATICAL PROGRESSION FROM HOSPITAL SPECIFIC TO NATIONAL RATE

[Dollar amounts in thousands]

	Assumed Medicare discharges	Year 1	Year 2	Year 3	Year 4	Difference between 50-50% and 100% (Col. 3−) (Col. 5)
Blend [percent]:						
Hospital specific		75	50	25		
Regional		25	37.5	37.5		
National			12.5	37.5	100	
PPS rate used as of		10–1–83	10–1–84	10–1–84	10–1–84	
Hospital specific cost	$570,100	$2,011,740	$2,135,000	$2,135,000	$2,135,000	0
Hospital DRG reimbursement	$570,100	$1,946,000	$1,976,000	$1,868,000	$1,750,000	($226,000)
Statewide impact PPS hospital	$570,100	($65,740)	($159,000)	($267,000)	($385,000)	($226,000)
Percentage reduction in reimbursement to hospital specific cost		3.3	7.4	12.5	18.0	10.6

The above information was developed from a survey including 206 of the 229 PPS eligible hospitals in Illinois, representing a sample size of 93%. The most recent data as of May 1, 1985 was used for this analysis.

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July 15, 1985

The Honorable John E. Porter
1131 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Porter:

Enclosed is the material you requested per the hearing of the Subcommittee on Health of the House Ways and Means held May 14, 1985.

The material represents the best estimates of the Illinois Hospital Association on the effect of a transition to 100% national rates under the Medicare Prospective Payment System's diagnostic related groupings (DRGs). Specific hospital names were omitted to protect confidentiality, however the information is arrayed by Congressional district for easy geographical reference.

Please contact me if either you or the Committee has questions on the attached material.

Very truly yours,

Jill E. Egan

Jill E. Egan
Assistant Vice President

The Center For Health Affairs
1151 East Warrenville Road
Naperville, IL 60566
312/357-9370

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MEDICARE PROSPECTIVE PAYMENT SYSTEM

ILLINOIS HOSPITALS

MODEL OF PROJECTED EXPERIENCE

The attached print out is a model of the projected experience of Illinois hospitals under the Medicare Prospective Payment System. The model makes the following assumptions:

- The full effect of each hospital's year under PPS according to Year 1, Year 2, Year 3, Year 4 under the system.
- A constant volume of Medicare Discharges
- Use of the Bureau of Labor Statistics' area wage data
- The DRG rates for Year 1 correspond to the regulations published January 3, 1984.
- The DRG rates for Years 2-4 correspond to the regulations published August 31, 1984.
- The hospital data was obtained from a survey of our 229 PPS eligible hospitals to which 207 hospitals responded. The hospitals submitted their audited PPS rate information as determined by their fiscal intermediary.
- The purpose of the model was to isolate the effect of the four year transition toward 100% national rates.

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The following are the explainations of the column headings on the print out:

OBS	Hospital observation. This merely counts the hospitals represented in the print out. There are a total of 207 observations.
CAREDIS	Medicare Dischares. This represents the hospital's best estimate of Medicare activity based on informed projections.
HSRATE	Hospital Specific Rate. The amount per the intermediaries' audit of the hospital's base year adjusted for inflation to be used as the basis for the transition.
HSCOST	Hospital Specific Cost. A multiplication of Medicare Discharges x Hospital Specific Rate.
RATE 1	The hospital's first year DRG rate under PPS.
TOTREV1	Medicare Discharges x RATE 1
DIFF 1	HSCOST - REV1

All other variations of the column headings correspond to the subsequent years of the transition.

TOT DIFF	DIFF1 + DIFF2 + DIFF3 + DIFF4
CAPPASS	Capital Pass through amount
DMEDED,IMEDED	Direct and Indirect Medical Education adjustments.

Hospital observations are grouped according to Congressional District. Subtotals appear under each district and the total state impact is summarized at the end of the print out.

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ILLINOIS HOSPITAL ASSOCIATION
SIMULATION OF MEDICARE GAINS AND LOSSES
DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
FOR SURVEYED HOSPITALS

CONGDIS=1

OBS	CAREDIS	HSRATE	HSCOST	RATE1	TOTREV1	DIFF1	RATE2	TOTREV2	DIFF2	RATE3
1	1599	5706.92	$9,125,365	5160.20	$8,251,163	$-874,202	4852.02	$7,758,376	$-1,903,378	4217.64
2	4615	4962.80	$22,903,322	4592.17	$21,192,865	$-1,710,457	4448.96	$20,531,951	$-3,814,281	3967.11
3	3045	6125.71	$18,652,787	5464.35	$16,638,954	$-2,013,833	5067.05	$15,429,157	$-4,398,755	4276.16
4	1260	4131.19	$5,205,299	3975.09	$5,008,614	$-196,685	4013.89	$5,057,502	$-460,271	3782.24
5	3154	4378.84	$13,810,861	4160.83	$13,123,251	$-687,610	4145.15	$13,073,800	$-1,566,127	3847.87
6	950	3540.62	$3,363,589	3532.16	$3,355,555	$-8,034	3700.88	$3,515,836	$-49,669	3625.74
7	4244	6302.65	$26,748,447	5597.06	$23,753,913	$-2,994,534	5161.09	$21,903,667	$-6,529,931	4323.18
8	882	4518.84	$3,985,617	4265.83	$3,762,460	$-223,157	4219.35	$3,721,468	$-503,405	3884.97
9	3872	5054.17	$19,569,746	4660.70	$18,046,221	$-1,523,525	4497.52	$17,414,410	$-3,388,230	3991.40
CONGDIS	23621		$123,365,034		$113,132,996	$-10,232,037		$108,406,167	$-22,614,049	

OBS	TOTREV3	DIFF3	RATE4	TOTREV4	DIFF4	TOTDIFF	CAPPASS	DMEDED	IMEDED
1	$6,744,008	$-2,917,746	3504.87	$5,604,282	$-4,057,472	$-9,752,798	1157617	55579	.
2	$18,308,229	$-6,038,002	3504.87	$16,174,960	$-8,171,272	$-19,734,011	1907490	2036216	1291862
3	$13,020,898	$-6,807,015	3504.87	$10,672,319	$-9,155,594	$-22,375,197	1889947	2637048	1553056
4	$4,765,628	$-752,145	3504.87	$4,416,132	$-1,101,642	$-2,510,743	2682409	.	.
5	$12,136,194	$-2,503,733	3504.87	$11,054,349	$-3,585,578	$-8,343,048	829140	913120	.
6	$3,444,452	$-121,053	3504.87	$3,329,623	$-235,882	$-414,638	200030	.	.
7	$18,347,570	$-10,086,028	3504.87	$14,874,654	$-13,558,945	$-33,169,438	1790256	4467856	2798739
8	$3,426,548	$-798,326	3504.87	$3,091,292	$-1,133,581	$-2,658,469	342000	.	.
9	$15,454,682	$-5,347,958	3504.87	$13,570,844	$-7,231,797	$-17,491,510	2361105	1687880	1130543
CONGDIS	$95,648,211	$-35,372,006		$82,788,455	$-48,231,762	-116449853	13159994	11797699	6774200

CONGDIS=2

OBS	CAREDIS	HSRATE	HSCOST	RATE1	TOTREV1	DIFF1	RATE2	TOTREV2	DIFF2
10	1100	4469.06	$4,915,966	4225.18	$4,647,697	$-268,269	4189.74	$4,608,715	$-609,632
11	1470	4730.10	$6,953,247	4424.27	$6,503,681	$-449,566	4331.32	$6,367,044	$-1,003,607
12	3431	4504.23	$15,454,013	4248.24	$14,575,721	$-878,292	4205.23	$14,428,144	$-1,999,472
13	6700	3422.73	$22,932,291	3443.75	$23,073,094	$140,803	3638.40	$24,377,256	$68,339
CONGDIS	12701		$50,255,517		$48,800,193	$-1,455,324		$49,781,159	$-3,544,371

OBS	RATE3	TOTREV3	DIFF3	RATE4	TOTREV4	DIFF4	TOTDIFF	CAPPASS	DMEDED	IMEDED
10	3853.84	$4,239,221	$-979,126	3504.87	$3,855,353	$-1,362,994	$-3,220,021	250367	.	.
11	3940.96	$5,793,212	$-1,577,439	3504.87	$5,152,154	$-2,218,496	$-5,249,108	475800	.	.
12	3845.25	$13,193,048	$-3,234,568	3504.87	$12,025,197	$-4,402,419	$-10,514,751	637621	.	.
13	3594.50	$24,083,134	$-225,782	3504.87	$23,482,606	$-826,310	$-842,950	1285000	600000	0
CONGDIS		$47,308,614	$-6,016,915		$44,515,311	$-8,810,219	$-19,826,829	2648788	600000	0

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                                   ILLINOIS HOSPITAL ASSOCIATION
                              SIMULATION OF MEDICARE GAINS AND LOSSES
                            DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                      FOR SURVEYED HOSPITALS
------------------------------------------------------------ CONGDIS=3 ------------------------------------------------------------

   OBS   CAREDIS   MSRATE          MSCOST    RATE1       TOTREV1          DIFF1    RATE2       TOTREV2             DIFF2     RATE3

    14     5500    3298.33    $18,140,815   3350.45   $18,427,450       $286,635   3572.46   $19,648,544          $418,736   3561.53
    15     5362    4341.81    $23,280,785   4126.43   $22,125,905    $-1,154,880   4118.90   $22,085,562      $-2,661,912   3802.09
    16     5223    4892.61    $25,554,102   4539.53   $23,709,953    $-1,844,149   4411.65   $23,042,069      $-4,121,941   3798.96
    17     8279    4450.60    $36,846,517   4214.65   $34,893,070    $-1,953,447   4183.18   $34,632,571      $-4,425,842   3866.89
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 CONGDIS  24364              $103,822,220             $99,156,378    $-4,665,841             $99,408,747     $-10,790,960

   OBS       TOTREV3            DIFF3    RATE4      TOTREV4             DIFF4          TOTDIFF    CAPPASS    DMEDED    IMEDED

    14    $19,588,419         $358,611   3504.87   $19,276,767         $46,958       $1,110,940    1764301         .         .
    15    $20,380,782      $-4,360,692   3504.87   $18,793,095     $-5,954,380     $-14,131,864     641029     36395         .
    16    $20,622,810      $-6,541,201   3504.87   $18,305,918     $-8,858,092     $-21,365,383    4137296    150345    129635
    17    $32,013,989      $-7,044,424   3504.87   $29,016,791    $-10,041,623     $-25,465,337    8981545   5610992         0
 --------  -----------     ------------            -----------    ------------     ------------   --------   -------    ------
 CONGDIS   $92,612,000    $-17,587,707             $85,392,571    $-24,807,136     $-57,851,645   15524116   5797732    129635

------------------------------------------------------------ CONGDIS=4 ------------------------------------------------------------

   OBS   CAREDIS   MSRATE          MSCOST    RATE1       TOTREV1          DIFF1    RATE2       TOTREV2             DIFF2     RATE3

    18     3043    3033.16     $9,229,906   3021.63    $9,194,821       $-35,085   3154.30    $9,598,531        $-185,446   3081.92
    19     2408    4063.24     $9,784,282   3788.50    $9,122,710      $-661,572   3695.12    $8,897,858      $-1,502,854   3329.39
    20     4450    3833.89    $17,060,810   3752.12   $16,696,914      $-363,897   3856.32   $17,160,612        $-924,359   3703.96
    21     2780    3707.06    $10,305,627   3652.57   $10,154,157      $-151,470   3784.05   $10,519,672        $-425,007   3645.55
    22     5150    3582.59    $18,450,338   3479.88   $17,921,382      $-528,957   3567.56   $18,372,937      $-1,258,224   3376.01
    23     3504    3106.39    $10,884,791   3127.80   $10,959,804        $75,013   3320.41   $11,634,721          $80,407   3277.58
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 CONGDIS  21335               $75,715,754             $74,049,788    $-1,665,967             $76,184,510      $-4,215,483

   OBS       TOTREV3            DIFF3    RATE4      TOTREV4             DIFF4          TOTDIFF    CAPPASS    DMEDED    IMEDED

    18     $9,378,285        $-405,692   2970.43    $9,039,019       $-744,958      $-1,371,181     703300         .         .
    19     $8,005,134      $-2,395,557   2970.43    $7,152,796     $-3,247,896      $-7,807,879    1238809      4853         .
    20    $16,480,389      $-1,604,582   3504.87   $15,596,657     $-2,488,314      $-5,381,152    3123709         .         .
    21    $10,134,628        $-810,051   3504.87    $9,743,529     $-1,201,149      $-2,587,677    1255850      1097         .
    22    $17,386,468      $-2,244,692   3222.68   $16,596,804     $-3,034,356      $-7,066,228          .         .         .
    23    $11,484,639         $-69,675   3222.68   $11,292,272       $-262,042        $-176,297     713856     46930         .
 --------  -----------     ------------            -----------    ------------     ------------   --------   -------    ------
 CONGDIS   $72,869,543     $-7,530,250             $69,421,077    $-10,979,715     $-24,390,415    7035524     52880         0
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                                        ILLINOIS HOSPITAL ASSOCIATION
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                                 DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                          FOR SURVEYED HOSPITALS
0------------------------------------------------------------ CONGDIS=5 ------------------------------------------------------------

     OBS   CAREDIS   MSRATE      MSCOST       RATE1      TOTREV1        DIFF1        RATE2      TOTREV2         DIFF2        RATE3

      24     6572   4408.37   $28,971,808   4174.14   $27,432,438   $-1,539,370   4152.13   $27,287,793   $-3,538,210   3807.81
      25     3720   3217.19   $11,967,947   3289.59   $12,237,276      $269,330   3529.46   $13,129,580      $443,198   3540.03
  --------  -----             -----------             -----------   -----------             -----------   -----------
  CONGDIS   10292             $40,939,754             $39,669,714   $-1,270,040             $40,417,374   $-3,095,012

     OBS      TOTREV3        DIFF3       RATE4      TOTREV4        DIFF4          TOTDIFF      CAPPASS    DMEDED     IMEDED

      24   $25,024,924   $-5,801,079   3504.87   $23,033,984   $-7,792,020   $-18,670,678    2854488    1525478     908100
      25   $13,168,904      $482,521   3504.87   $13,038,104      $351,721     $1,546,770    1661947     188380          0
  --------  -----------   -----------             -----------   -----------   ------------   -------    -------     ------
  CONGDIS   $38,193,829   $-5,318,557             $36,072,087   $-7,440,299   $-17,123,908    4516435    1713858     908100

1------------------------------------------------------------ CONGDIS=6 ------------------------------------------------------------

     OBS   CAREDIS   MSRATE      MSCOST       RATE1      TOTREV1        DIFF1        RATE2      TOTREV2          DIFF2       RATE3

      26     3057   5043.02   $15,418,546   4659.41   $14,243,825   $-1,174,721   4497.49   $13,748,834    $-2,595,075   4029.05
      27     5579   3422.58   $19,094,574   3437.01   $19,175,052       $80,478   3630.33   $20,253,628       $-43,909   3557.60
      28      683   4961.94    $3,389,005   4598.15    $3,140,538     $-248,467   4459.20    $3,042,219      $-550,228   4002.40
      29      466   3109.09    $1,448,836   3208.52    $1,495,168       $46,332   3472.16    $1,618,028        $82,216   3511.38
      30     6700   5565.52   $37,288,784   5044.21   $33,796,208   $-3,492,576   4769.31   $31,954,349    $-7,683,834   4127.29
  --------  -----             -----------             -----------   -----------             -----------    -----------
  CONGDIS   16485             $76,639,745             $71,850,792   $-4,788,953             $70,617,058   $-10,790,830

     OBS      TOTREV3               DIFF3       RATE4      TOTREV4          DIFF4           TOTDIFF      CAPPASS    DMEDED     IMEDED

      26   $12,301,507        $-4,042,402   3504.87   $10,714,377    $-5,629,532    $-13,441,531      939736      21213          .
      27   $19,848,967          $-448,565   3504.87   $19,553,651      $-743,881     $-1,155,872     1748838          .          .
      28    $2,733,639          $-858,808   3504.87    $2,393,829    $-1,198,623     $-2,856,125       71690          .          .
      29    $1,636,303           $100,494   3504.87    $1,633,268        $97,458        $326,503     1414370     177766          0
      30   $27,652,819       $-11,985,371   3504.87   $23,482,606   $-16,155,584    $-39,317,572     2273063    4097721    1132409
  --------  ------------      ------------             -----------   ------------    ------------     -------    -------    -------
  CONGDIS   $64,173,236       $-17,234,652             $57,777,727   $-23,630,162    $-56,444,597     7312667    4296700    1132409
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                             DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                      FOR SURVEYED HOSPITALS
------------------------------------------------------- CONGDIS=7 -----------------------------------------------------------

   OBS   CAREDIS   HSRATE        HSCOST    RATE1      TOTREV1          DIFF1    RATE2       TOTREV2          DIFF2     RATE3

    31     591    4121.09    $2,435,564   3967.52   $2,344,802      $-90,763   4008.54    $2,369,046     $-212,725   3779.57
    32    8300    5741.68   $47,655,944   5174.12  $42,945,209   $-4,710,740   4861.45   $40,350,036  $-10,355,888   4162.47
    33    4100    5699.99   $23,369,959   5152.80  $21,126,480   $-2,243,479   4846.36   $19,870,072   $-4,892,970   4203.92
    34     294    4811.30    $1,414,522   4478.55   $1,316,692      $-97,830   4368.44    $1,284,321     $-219,316   3926.85
    35    1100    4917.14    $5,408,854   4567.87   $5,024,653     $-384,201   4433.92    $4,877,308     $-849,479   4008.59
    36    1356    4327.45    $5,868,022   4113.45   $5,577,836     $-290,186   4109.08    $5,571,912     $-671,663   3786.28
    37    1170    5023.38    $5,877,355   4637.61   $5,425,999     $-451,357   4481.16    $5,242,955   $-1,004,673   3983.21
    38    4532    4882.30   $22,126,584   4531.80  $20,538,096   $-1,588,488   4406.17   $19,968,782   $-3,551,777   3945.72
    39    2300    6241.71   $14,355,933   5551.35  $12,768,111   $-1,587,822   5128.70   $11,796,012   $-3,464,345   4306.98
    40    8433    6530.80   $55,074,236   5768.17  $48,642,979   $-6,431,257   5282.35   $44,546,075  $-13,997,839   4383.81
    41    1808    4260.52    $7,703,020   4072.09   $7,362,335     $-340,685   4082.44    $7,381,047     $-784,385   3816.52
    42    2951    4403.07   $12,993,460   4179.00  $12,332,230     $-661,229   4157.99   $12,270,232   $-1,503,225   3854.30
    43    4481    3121.60   $13,987,890   3211.27  $14,389,702      $401,812   3470.36   $15,550,673      $681,566   3477.81
    44    5000    3413.04   $17,065,200   3438.69  $17,193,436      $128,236   3636.20   $18,180,998      $105,538   3604.29
    45    3336    3580.78   $11,945,482   3562.28  $11,883,776      $-61,706   3722.17   $12,417,143     $-245,426   3636.38
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CONGDIS  49752             $247,282,025           $228,872,310  $-18,409,715            $221,676,632  $-40,966,506

   OBS       TOTREV3          DIFF3    RATE4       TOTREV4          DIFF4        TOTDIFF   CAPPASS    DMEDED    IMEDED

    31    $2,233,725      $-348,046   3504.87    $2,071,376     $-510,395    $-1,161,929   1137304         .         .
    32   $34,548,501   $-16,157,423   3504.87   $29,090,393  $-21,615,531   $-52,839,583   5198000   4902000   3692000
    33   $17,236,085    $-7,526,957   3504.87   $14,369,953  $-10,393,089   $-25,056,515    594000   2821000   1119000
    34    $1,154,495      $-349,142   3504.87    $1,030,431     $-473,206    $-1,159,495    275450         .         .
    35    $4,409,449    $-1,317,337   3504.87    $3,855,353   $-1,871,433    $-4,422,499    464000     66000     12387
    36    $5,134,202    $-1,109,373   3504.87    $4,752,599   $-1,490,976    $-3,562,199    766147         .         .
    37    $4,660,359    $-1,587,269   3504.87    $4,100,694   $-2,146,934    $-5,190,232    230000         .         .
    38   $17,882,006    $-5,638,552   3504.87   $15,884,056   $-7,636,503   $-18,415,319   1584723   2577416   2803242
    39    $9,906,063    $-5,354,294   3504.87    $8,061,193   $-7,199,164   $-17,605,624   1445609   1494107    973310
    40   $36,968,666   $-21,575,247   3504.87   $29,556,540  $-28,987,373   $-70,971,716   5951946   7126418   4010786
    41    $6,900,265    $-1,265,167   3504.87    $6,336,799   $-1,828,634    $-4,218,871   1199990   1703729         .
    42   $11,374,025    $-2,399,432   3504.87   $10,342,861   $-3,430,595    $-7,994,482   1044139         .         .
    43   $15,584,088       $714,961   3504.87   $15,705,307      $836,181     $2,634,520    943040         .         .
    44   $18,021,439       $-54,021   3504.87   $17,524,333     $-551,127      $-371,374  10320000   1901000         0
    45   $12,130,970      $-531,599   3504.87   $11,692,235     $-970,334    $-1,809,065   1282051         .         .
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CONGDIS $198,144,339  $-64,498,900            $174,374,125  $-88,269,114     -212144335  32436899  22591670  12610725
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                                   ILLINOIS HOSPITAL ASSOCIATION
                             SIMULATION OF MEDICARE GAINS AND LOSSES
                            DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                       FOR SURVEYED HOSPITALS
0------------------------------------------------------ CONGDIS=8 ------------------------------------------------------

     OBS   CAREDIS   MSRATE      MSCOST       RATE1      TOTREV1        DIFF1        RATE2      TOTREV2         DIFF2       RATE3

      46     2144    5519.31   $11,833,401   5009.55   $10,740,481   $-1,092,920   4744.75   $10,172,733   $-2,406,171   4115.01
      47     3073    5601.23   $17,212,580   5078.73   $15,606,922   $-1,605,658   4799.04   $14,732,071   $-3,506,550   4177.76
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   CONGDIS   5217              $29,045,980             $26,347,403   $-2,698,577             $24,904,805   $-5,912,722

     OBS        TOTREV3        DIFF3       RATE4       TOTREV4          DIFF4         TOTDIFF       CAPPASS    DMEDED    IMEDED

      46      $8,822,573   $-3,756,332   3504.87    $7,514,434    $-5,064,471   $-12,319,894     942300      20846         0
      47     $12,838,261   $-5,400,361   3504.87   $10,770,455    $-7,468,166   $-17,980,735    2203178    1179042    412990
   --------  -----------   -----------             -----------    -----------   ------------    -------    -------    ------
   CONGDIS   $21,660,834   $-9,156,692             $18,284,889   $-12,532,637   $-30,300,629    3145478    1199888    412990

0------------------------------------------------------ CONGDIS=9 ------------------------------------------------------

     OBS   CAREDIS   MSRATE           MSCOST    RATE1         TOTREV1         DIFF1   RATE2          TOTREV2          DIFF2    RATE3

      48     1250    5714.14      $7,142,675   5155.68      $6,444,594      $-698,081   4848.30      $6,060,372   $-1,532,292   4166.78
      49     2494    5265.58     $13,132,357   4825.88     $12,035,752    $-1,096,605   4615.13     $11,510,148   $-2,410,546   4082.87
      50     3182    3493.04     $11,114,853   3496.48     $11,125,793        $10,939   3675.66     $11,695,956      $-80,122   3613.13
      51     4172    4481.14     $18,695,316   4234.24     $17,665,245    $-1,030,071   4196.15     $17,506,348   $-2,338,917   3857.09
      52     3700    4869.98     $18,018,926   4532.50     $16,770,238    $-1,248,688   4408.95     $16,313,115   $-2,764,963   3996.11
      53     5636    4007.11     $22,584,072   3876.51     $21,847,995      $-736,077   3942.21     $22,218,277   $-1,777,525   3719.18
      54     5500    4940.45     $27,172,475   4575.41     $25,164,742    $-2,007,733   4437.08     $24,403,998   $-4,480,395   3961.17
      55     7200    4109.69     $29,589,768   3962.28     $28,528,411    $-1,061,357   4006.46     $28,846,513   $-2,482,542   3794.86
      56     5900    3877.99     $22,880,141   3785.19     $22,332,623      $-547,518   3879.69     $22,890,177   $-1,363,459   3715.19
      57     3069    3382.82     $10,381,875   3417.13     $10,487,162       $105,287   3621.66     $11,114,882      $122,761   3602.46
   --------  -----               ------------              -----------    -----------              ------------   -----------
   CONGDIS   42103              $180,712,457              $172,402,556    $-8,309,902              $172,559,731  $-19,114,001

     OBS       TOTREV3           DIFF3   RATE4        TOTREV4          DIFF4         TOTDIFF    CAPPASS     DMEDED    IMEDED

      48      $5,208,478    $-2,384,186   3504.87     $4,381,083    $-3,211,580    $-7,826,139     600000      40000     15000
      49     $10,182,669    $-3,738,022   3504.87     $8,741,137    $-5,179,554   $-12,424,728    2324718     402976         .
      50     $11,496,981      $-285,097   3504.87    $11,152,486      $-629,592      $-989,872     937861          0         0
      51     $16,091,582    $-3,753,683   3504.87    $14,622,304    $-5,222,961   $-12,345,632    1063823    1573564    427129
      52     $14,785,597    $-4,292,481   3504.87    $12,968,007    $-6,110,072   $-14,416,209    1721719    4439579   1251615
      53     $20,961,306    $-3,034,497   3504.87    $19,753,428    $-4,242,374    $-9,790,472    1320000    1986000    926000
      54     $21,786,457    $-7,097,884   3504.87    $19,276,767    $-9,607,574   $-23,193,586    1800000    2900000   1100000
      55     $27,323,009    $-4,006,045   3504.87    $25,235,040    $-6,094,015   $-13,643,959    2584946    2198820         .
      56     $21,919,355    $-2,334,281   3504.87    $20,678,713    $-3,574,923    $-7,820,180    2208000    1499000   1183000
      57     $11,055,961        $63,839   3504.87    $10,756,436      $-235,685        $56,202     431317      99409         .
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   CONGDIS   $160,811,395   $-30,862,367              $147,565,400   $-44,108,331     -102394571   14992384   15138888   4900744
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                                          ILLINOIS HOSPITAL ASSOCIATION
                                     SIMULATION OF MEDICARE GAINS AND LOSSES
                                   DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                            FOR SURVEYED HOSPITALS
----------------------------------------------------------- CONGDIS=10 -----------------------------------------------------------

     OBS   CAREDIS   MSRATE       MSCOST      RATE1      TOTREV1       DIFF1      RATE2       TOTREV2         DIFF2     RATE3

      58     3200   3996.55  $12,788,960   3874.11  $12,397,153   $-391,807   3942.53   $12,616,095     $-940,587   3746.56
      59     3182   3493.04  $11,114,853   3432.03  $10,920,725   $-194,128   3533.54   $11,243,714     $-538,364   3403.57
      60     1600   3006.98   $4,811,168   3067.49   $4,907,979     $96,811   3275.92    $5,241,468      $141,486   3274.76
      61     1926   3130.41   $6,029,170   3160.06   $6,086,274     $57,104   3341.34    $6,435,416       $44,315   3307.47
      62     5012   2969.56  $14,883,435   3106.08  $15,567,659    $684,224   3401.33   $17,047,479    $1,282,945   3486.85
      63     3154   3405.96  $10,742,398   3366.72  $10,618,640   $-123,758   3487.38   $10,999,206     $-388,058   3380.50
      64     3652   3286.72  $12,003,101   3277.29  $11,968,569    $-34,432   3424.18   $12,505,120     $-218,527   3348.90
      65      479   5735.64   $2,747,372   5107.82   $2,446,645   $-300,726   4718.57    $2,260,194     $-660,262   3965.84
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  CONGDIS   22205            $75,120,456            $74,913,744   $-206,712             $78,348,693  $-1,277,051

     OBS     TOTREV3        DIFF3       RATE4     TOTREV4        DIFF4           TOTDIFF     CAPPASS    DNEDED    INEDED

      58  $11,989,005   $-1,567,676   3504.87  $11,215,573   $-2,341,108     $-5,241,177     5133700         .         .
      59  $10,830,171     $-951,907   3231.27  $10,281,891   $-1,560,187     $-3,184,586      937861         .         .
      60   $5,239,622      $139,640   3231.27   $5,170,027       $70,044        $447,981      750000         .         .
      61   $6,370,195      $-20,906   3231.27   $6,223,420     $-167,681        $-87,167      524854         .         .
      62  $17,476,114    $1,711,580   3504.87  $17,566,392    $1,801,858      $5,480,606     1700835         .         .
      63  $10,662,087     $-725,177   3231.27  $10,191,415   $-1,195,849     $-2,432,841     1053312     27352         .
      64  $12,230,173     $-493,475   3231.27  $11,800,586     $-923,062     $-1,669,496     1049321         .         .
      65   $1,899,539   $-1,020,817   3231.27   $1,547,777   $-1,372,679     $-3,354,484      689098         0         0
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  CONGDIS  $76,697,005   $-2,928,738            $73,997,080   $-5,628,664    $-10,041,166    11838981     27352         0

----------------------------------------------------------- CONGDIS=11 -----------------------------------------------------------

     OBS   CAREDIS   MSRATE          MSCOST   RATE1        TOTREV1        DIFF1   RATE2        TOTREV2         DIFF2    RATE3

      66     1901   3876.30    $7,368,846   3787.24     $7,199,537    $-169,309  3882.91     $7,381,404     $-420,583  3733.09
      67     1479   5268.25    $7,791,742   4827.89     $7,140,443    $-651,299  4616.55     $6,827,877   $-1,431,603  4083.57
      68     7238   2933.37   $21,231,732   3072.31    $22,237,358   $1,005,625  3373.22    $24,415,377    $1,867,065  3440.13
      69     3441   4166.28   $14,336,169   4003.62    $13,776,447    $-559,723  4035.12    $13,884,832   $-1,300,038  3803.75
      70     7500   3253.00   $24,397,500   3309.82    $24,823,651     $426,151  3540.20    $26,551,510      $616,967  3512.73
      71     4200   4010.48   $16,844,016   3884.56    $16,315,143    $-528,873  3949.91    $16,589,633   $-1,265,529  3750.26
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  CONGDIS   25759             $91,970,006              $91,492,578    $-477,427             $95,650,633   $-1,933,721

     OBS       TOTREV3          DIFF3    RATE4        TOTREV4        DIFF4         TOTDIFF     CAPPASS     DNEDED    INEDED

      66    $7,096,595      $-705,392  3504.87     $6,662,751  $-1,139,236     $-2,434,520     821109          .         .
      67    $6,039,606    $-2,219,874  3504.87     $5,183,698  $-3,075,782     $-7,378,558     657905          .         .
      68   $24,899,682     $2,351,370  3504.87    $25,368,225   $2,819,913      $8,043,973     659100          .         .
      69   $13,088,689    $-2,096,182  3504.87    $12,060,246  $-3,124,625     $-7,080,567    1639603    1743258    441411
      70   $26,345,507       $410,964  3504.87    $26,286,500     $351,957      $1,806,040    1380263     630279    627770
      71   $15,751,074    $-2,104,088  3504.87    $14,720,440  $-3,134,722     $-7,033,212    2108000     781000    317000
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  CONGDIS  $93,221,153    $-4,563,201              $90,281,860  $-7,302,495    $-14,076,844    7265980    3154537   1386181
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                                     ILLINOIS HOSPITAL ASSOCIATION
                                SIMULATION OF MEDICARE GAINS AND LOSSES
                               DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                         FOR SURVEYED HOSPITALS
------------------------------------------------------ CONGDIS=12 -------------------------------------------------------

    OBS   CAREDIS   HSRATE        HSCOST    RATE1       TOTREV1      DIFF1    RATE2       TOTREV2       DIFF2     RATE3

     72    1842    3681.34   $6,781,028   3573.26   $6,581,939  $-199,089  3633.34   $6,692,610  $-495,484   3453.47
     73     400    2944.68   $1,177,872   3081.09   $1,232,758    $54,886  3380.67   $1,352,267   $101,945   3449.30
     74    1870    3444.20   $6,440,654   3451.01   $6,453,390    $12,736  3639.19   $6,805,287   $-47,569   3551.34
     75    2315    3875.24   $8,971,181   3783.13   $8,757,941  $-213,239  3878.23   $8,978,111  $-531,610   3714.42
     76    1366    3245.02   $4,432,697   3313.78   $4,526,619    $93,922  3548.71   $4,847,541   $154,290   3565.99
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 CONGDIS   7793             $27,803,432             $27,552,647  $-250,785             $28,675,816  $-818,428

    OBS        TOTREV3         DIFF3    RATE4        TOTREV4        DIFF4          TOTDIFF    CAPPASS   DMEDED    IMEDED

     72     $6,361,300     $-826,793   3231.27    $5,951,993   $-1,236,100    $-2,757,467    2608927      .         .
     73     $1,379,720      $129,397   3504.87    $1,401,947      $151,624       $437,851      64984      .         .
     74     $6,641,006     $-211,849   3504.87    $6,554,101     $-298,755      $-545,437     858575      .         .
     75     $8,598,873     $-910,847   3504.87    $8,113,766   $-1,395,954    $-3,051,651    2056700      .         .
     76     $4,871,140      $177,889   3504.87    $4,787,648       $94,397       $520,497     416000      .         .
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 CONGDIS   $27,852,040   $-1,642,204             $26,809,455   $-2,684,789    $-5,396,206    6005186      0         0

------------------------------------------------------ CONGDIS=13 -------------------------------------------------------

    OBS   CAREDIS   HSRATE       HSCOST       RATE1      TCTREV1       DIFF1    RATE2       TOTREV2        DIFF2      RATE3

     77    4650    4265.30   $19,833,645   4075.67   $18,951,879   $-881,766  4084.97   $18,995,116   $-2,029,143   3817.78
     78    2937    3532.69   $10,375,511   3526.22   $10,356,495    $-19,016  3696.68   $10,857,140     $-141,213   3623.64
     79    4320    3470.90   $14,994,288   3479.87   $15,033,051     $38,763  3663.93   $15,828,166      $-66,229   3607.26
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 CONGDIS   11907             $45,203,444             $44,541,425   $-862,019            $45,680,421   $-2,236,595

    OBS     TOTREV3          DIFF3       RATE4     TOTREV4         DIFF4           TOTDIFF     CAPPASS   DMEDED    IMEDED

     77   $17,752,700   $-3,271,559   3504.87   $16,297,630   $-4,726,629    $-10,909,096    1485718        .         .
     78   $10,642,624     $-355,728   3504.87   $10,293,793     $-704,559     $-1,220,516    5465620        .         .
     79   $15,585,376     $-311,019   3504.87   $15,141,024     $-753,371     $-1,091,857    2290000   910110         0
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 CONGDIS   $43,978,701   $-3,938,306            $41,732,447   $-6,184,559    $-13,221,468    9241338   910110         0
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                                      ILLINOIS HOSPITAL ASSOCIATION
                                   SIMULATION OF MEDICARE GAINS AND LOSSES
                                  DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                          FOR SURVEYED HOSPITALS
0------------------------------------------------------ CONGDIS=14 ---------------------------------------------------------

   OBS  CAREDIS   HSRATE        HSCOST     RATE1       TOTREV1        DIFF1    RATE2       TOTREV2          DIFF2     RATE3

    80     1224   2334.76   $2,857,746   2283.34    $2,794,809     $-62,937   2345.92    $2,871,401      $-163,555   2238.83
    81     2154   3476.43   $7,488,230   3346.50    $7,208,354    $-279,876   3381.24    $7,283,189      $-684,288   3158.14
    82     4000   3422.21  $13,688,840   3309.62   $13,238,499    $-450,341   3356.44   $13,425,756    $-1,111,929   3164.37
    83     1330   3167.23   $4,212,416   3119.34    $4,148,720     $-63,696   3222.11    $4,285,412      $-186,110   3101.86
    84     2133   2691.41   $5,740,778   2549.40    $5,437,868    $-302,909   2533.80    $5,404,604      $-697,842   2325.71
    85      874   2040.33   $1,783,248   2063.23    $1,803,265      $20,017   2190.47    $1,914,475        $21,539   2164.64
    86     4200   3885.47  $16,318,974   3784.17   $15,893,525    $-425,449   3876.36   $16,280,708    $-1,000,361   3680.81
    87     1722   2690.25   $4,632,611   2549.96    $4,391,028    $-241,583   2534.68    $4,364,723      $-555,156   2333.21
    88     1140   2826.84   $3,222,598   2859.30    $3,259,607      $37,009   3035.66    $3,460,649        $31,805   2985.35
    89      727   2071.07   $1,505,668   2090.57    $1,519,847      $14,179   2212.44    $1,608,446        $14,275   2196.82
    90     2600   3106.11   $8,075,886   2860.42    $7,437,103    $-638,783   2754.22    $7,160,965    $-1,423,702   2435.91
    91      562   2360.41   $1,326,550   2302.58    $1,294,049     $-32,502   2359.54    $1,326,059       $-82,751   2245.64
    92     4124   3217.42  $13,268,640   3283.14   $13,539,650     $271,009   3521.29   $14,521,802       $417,238   3503.29
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CONGDIS   26790           $84,122,185             $81,986,323  $-2,155,861             $83,908,188   $-5,486,837

   OBS        TOTREV3          DIFF3    RATE4       TOTREV4          DIFF4         TOTDIFF    CAPPASS   DMEDED    IMEDED

    80     $2,740,325       $-294,630   2130.33    $2,607,521       $-427,435       $-948,556    408127     2101       .
    81     $6,802,635     $-1,164,842   2970.43    $6,398,307     $-1,569,170     $-3,698,177    623551        .       .
    82    $12,657,463     $-1,880,222   2970.43   $11,881,721     $-2,655,964     $-6,098,456   1413826        .       .
    83     $4,125,473       $-346,048   2970.43    $3,950,672       $-520,849     $-1,116,704    250000        .       .
    84     $4,960,732     $-1,141,715   2130.33    $4,543,988     $-1,558,458     $-3,700,925    657500        .       .
    85     $1,891,896         $-1,040   2130.33    $1,861,906        $-31,030          $7,485     86242        .       .
    86    $15,459,415     $-1,887,654   3504.87   $14,720,440     $-2,626,629     $-6,006,093    511732        .       .
    87     $4,017,790       $-902,089   2130.33    $3,668,424     $-1,251,455     $-2,950,282    460902        .       .
    88     $3,403,299        $-25,545   2970.43    $3,386,290        $-42,553            $716    150773        .       .
    89     $1,597,090          $2,919   2130.33    $1,548,748        $-45,423        $-14,050     92274        .       .
    90     $6,333,374     $-2,251,293   2130.33    $5,538,851     $-3,045,816     $-7,359,594    249432        .       .
    91     $1,262,049       $-146,761   2130.33    $1,197,244       $-211,566       $-473,579     60942        .       .
    92    $14,447,522        $342,958   3504.87   $14,454,070       $349,506      $1,380,710   1419500        0       0
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CONGDIS $79,699,032     $-9,695,963             $75,758,181   $-13,636,845    $-30,975,506   6384801     2101       0
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                                 ILLINOIS HOSPITAL ASSOCIATION
                            SIMULATION OF MEDICARE GAINS AND LOSSES
                          DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                    FOR SURVEYED HOSPITALS
--------------------------------------------------- CONGDIS=15 -------------------------------------------------------

    OBS   CAREDIS   HSRATE        HSCOST     RATE1       TOTREV1      DIFF1    RATE2       TOTREV2       DIFF2     RATE3

     93     1985    1973.04   $3,916,484   2238.97   $4,444,357   $527,873   2614.54   $5,189,854  $1,041,513   2840.14
     94     1514    2845.19   $4,307,618   2894.04   $4,381,583    $73,966   3077.71   $4,659,658     $98,839   3076.44
     95      200    2991.90     $598,380   2781.20     $556,239   $-42,141   2699.92     $539,984    $-93,569   2440.56
     96      813    2602.45   $2,115,792   2484.11   $2,019,580   $-96,212   2488.06   $2,022,793   $-224,199   2309.90
     97      720    2573.90   $1,853,208   2465.55   $1,775,198   $-78,010   2476.00   $1,782,723   $-181,733   2318.00
     98     1450    1330.00   $1,928,500   1534.77   $2,225,419   $296,919   1820.13   $2,639,185    $597,327   2000.66
     99     3038    3094.42   $9,400,848   3020.26   $9,175,540  $-225,308   3088.88   $9,384,027   $-581,154   2953.83
    100     3713    2576.52   $9,566,619   2631.83   $9,771,991   $205,373   2814.39  $10,449,824    $308,921   2816.58
    101     1545    2350.30   $3,631,213   2300.00   $3,553,495   $-77,719   2360.26   $3,646,608   $-198,049   2270.73
    102     1340    2394.25   $3,208,295   2597.75   $3,480,981   $272,686   2948.21   $3,950,601    $551,060   3111.59
    103     1907    2580.99   $4,921,948   2687.25   $5,124,579   $202,631   2926.34   $5,580,522    $348,492   2958.35
    104     1070    2748.45   $2,940,841   2598.61   $2,780,512  $-160,330   2571.04   $2,751,013   $-362,691   2376.12
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CONGDIS    19295             $48,389,747             $49,289,475   $899,728             $52,596,793  $1,304,758

    OBS        TOTREV3        DIFF3      RATE4        TOTREV4         DIFF4          TOTDIFF    CAPPASS    DMEDED    IMEDED

     93     $5,637,674   $1,489,334    3007.33     $5,969,546    $1,821,206      $4,879,926    1025000    135000       0
     94     $4,657,727      $96,907    3007.33     $4,553,094       $-7,725        $261,986     350000         .       .
     95       $488,112    $-145,441    2130.33       $426,065     $-207,487       $-488,637      81000         0       0
     96     $1,877,949    $-369,043    2130.33     $1,731,956     $-515,036     $-1,204,490     156117         .       .
     97     $1,668,963    $-295,493    2130.33     $1,533,836     $-430,620       $-985,856     101177         .       .
     98     $2,900,964     $859,107    2130.33     $3,088,975    $1,047,117      $2,800,470      50000      5000       .
     99     $8,973,734    $-991,447    2782.00     $8,451,706   $-1,513,475     $-3,311,384     847900         .       .
    100    $10,457,969     $317,066    2782.00    $10,329,553      $188,651      $1,020,011    2504741         .       .
    101     $3,508,283    $-336,374    2130.33     $3,291,356     $-553,301     $-1,165,441     315862         .       .
    102     $4,169,533     $769,992    3222.68     $4,318,392      $918,850      $2,512,588     622000         .       .
    103     $5,641,578     $409,548    3007.33     $5,734,974      $502,944      $1,463,614     422348         .       .
    104     $2,542,450    $-571,254    2130.33     $2,279,450     $-834,254     $-1,928,529     115128         .       .
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CONGDIS    $52,524,937   $1,232,903               $51,708,903      $416,869      $3,854,258    6571273    140000       0
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                                        ILLINOIS HOSPITAL ASSOCIATION
                                   SIMULATION OF MEDICARE GAINS AND LOSSES
                                  DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                          FOR SURVEYED HOSPITALS
------------------------------------------------------------ CONGDIS=16 ------------------------------------------------------------

    OBS   CAREDIS   HSRATE          HSCOST    RATE1        TOTREV1        DIFF1    RATE2        TOTREV2         DIFF2    RATE3

    105       599   1946.41     $1,165,900  2229.18     $1,335,280     $169,380  2617.67     $1,567,986      $329,206  2835.01
    106      1646   2742.67     $4,514,435  2592.13     $4,266,647    $-247,788  2565.46     $4,222,739     $-562,697  2362.73
    107      2620   2395.79     $6,276,970  2326.97     $6,096,660    $-180,309  2375.87     $6,224,774     $-450,783  2243.21
    108       340   1779.11       $604,897  1871.60       $636,345      $31,448  2057.88       $699,680       $59,226  2119.54
    109       357   1953.45       $697,382  1995.93       $712,547      $15,165  2141.58       $764,544       $23,227  2129.59
    110       564   2432.98     $1,372,201  2357.01     $1,329,351     $-42,850  2398.07     $1,352,512     $-104,779  2264.91
    111      5006   2549.68    $12,763,698  2684.58    $13,438,997     $675,299  2942.01    $14,727,700    $1,185,161  3011.54
    112      2700   3031.94     $8,186,238  3051.18     $8,238,186      $51,948  3204.03     $8,650,893      $-16,533  3166.50
    113      4337   2830.34    $12,275,185  2892.13    $12,543,163     $267,978  3087.27    $13,389,468      $346,962  3069.80
    114       348   1918.95       $667,795  1971.40       $686,076      $18,281  2125.12       $739,541       $50,337  2128.43
    115      2022   2392.32     $4,837,271  2326.51     $4,704,204    $-133,067  2376.48     $4,805,243     $-331,987  2254.11
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  CONGDIS   20539              $53,361,970             $53,987,456     $625,486             $57,145,079     $507,340

    OBS        TOTREV3        DIFF3    RATE4        TOTREV4          DIFF4          TOTDIFF   CAPPASS   DMEDED   IMEDED

    105     $1,698,170     $459,390  3060.01     $1,832,943       $594,163       $1,552,140     65130        .        .
    106     $3,889,053    $-896,383  2130.33     $3,506,519    $-1,278,918      $-2,985,785    139000        .        .
    107     $5,877,198    $-798,360  2130.33     $5,581,457    $-1,094,100      $-2,523,552    595191    33289        .
    108       $720,644      $80,191  2130.33       $724,311        $83,858         $254,723     40000        .        .
    109       $760,265      $18,948  2130.33       $760,527        $19,210          $76,550     50661        .        .
    110     $1,277,407    $-179,884  2130.33     $1,201,505      $-255,786        $-583,299    124800        .        .
    111    $15,075,700   $1,533,241  3060.01    $15,318,389     $1,775,850       $5,169,550   9600000   390000        .
    112     $8,549,540    $-117,885  3060.01     $8,262,015      $-405,410        $-487,880    884900   136700        0
    113    $13,313,743     $271,236  3060.01    $13,271,245       $228,738       $1,114,915    756600   111800    52000
    114       $740,693      $31,489  2130.33       $741,354        $32,149         $112,256     23820        .        .
    115     $4,557,811    $-579,419  2130.33     $4,307,522      $-829,708      $-1,874,182    700000        .        .
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  CONGDIS  $56,460,304    $-177,436             $55,507,787    $-1,129,953        $-174,564  12980102   671789    52000
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                                  ILLINOIS HOSPITAL ASSOCIATION
                             SIMULATION OF MEDICARE GAINS AND LOSSES
                           DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                    FOR SURVEYED HOSPITALS
-------------------------------------------------- CONGDIS=17 --------------------------------------------------

   OBS   CAREDIS   HSRATE        HSCOST    RATE1       TOTREV1       DIFF1   RATE2       TOTREV2         DIFF2    RATE3

   116      892    2315.68   $2,065,587   2267.60   $2,022,701     $-42,886  2334.10   $2,082,021     $-113,698  2225.80
   117     2600    2740.05   $7,124,130   2585.88   $6,723,286    $-400,844  2559.66   $6,655,107     $-917,843  2338.63
   118     1765    2590.48   $4,572,197   2676.03   $4,723,200     $151,003  2898.10   $5,115,139      $254,894  2912.15
   119     2944    2673.48   $7,870,725   2537.38   $7,470,048    $-400,677  2525.78   $7,435,889     $-922,900  2328.76
   120     2150    2721.58   $5,850,967   2716.35   $5,840,146     $-10,821  2844.28   $6,115,203      $-79,684  2795.25
   121      755    1834.82   $1,385,289   2110.23   $1,593,222     $207,933  2497.86   $1,885,884      $414,000  2716.64
   122     1500    2316.27   $3,474,405   2478.82   $3,718,237     $243,832  2764.08   $4,146,123      $467,493  2886.68
   123     2396    2351.97   $5,635,320   2294.82   $5,498,387    $-136,934  2353.39   $5,638,727     $-351,618  2235.56
   124     2933    2751.86   $8,071,205   2805.52   $8,228,582     $157,377  2994.68   $8,783,394      $237,763  3001.98
   125     2050    2921.45   $5,988,972   2927.08   $6,000,509      $11,537  3077.37   $6,308,606      $-48,748  3015.63
   126     1062    2086.79   $2,216,171   2097.36   $2,227,399      $11,229  2214.24   $2,351,525       $-2,071  2172.99
   127     1572    2146.29   $3,373,968   2141.99   $3,367,205      $-6,763  2245.84   $3,530,456      $-52,732  2188.79
   128     2494    3228.56   $8,051,879   3155.49   $7,869,786    $-182,093  3238.26   $8,076,218     $-478,984  3086.84
   129     2053    2438.35   $5,005,933   2366.03   $4,857,468    $-148,465  2406.88   $4,941,318     $-358,863  2294.04
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 CONGDIS  27166             $70,686,748            $70,140,177    $-546,572           $73,065,608   $-1,952,993

   OBS      TOTREV3         DIFF3     RATE4       TOTREV4         DIFF4        TOTDIFF    LAPPASS    DMEDED    IMEDED

   116   $1,985,464     $-210,255   2130.33   $1,900,252     $-295,467      $-662,305    241306          .         .
   117   $6,080,444   $-1,492,506   2130.33   $5,538,851   $-2,034,099    $-4,845,293   1205000     275000         .
   118   $5,139,940      $279,694   2942.81   $5,194,068      $333,823     $1,019,414    339508          .         .
   119   $6,855,866   $-1,502,922   2130.33   $6,271,683   $-2,087,105    $-4,913,605    766800          .         .
   120   $6,009,791     $-185,096   2685.23   $5,773,238     $-421,648      $-697,250     75000          0         .
   121   $2,051,067      $579,183   2942.81   $2,221,825      $749,942     $1,951,058     70000          .         .
   122   $4,330,021      $651,391   2942.81   $4,414,222      $735,592     $2,098,307    471000          .         .
   123   $5,356,259     $-634,087   2130.33   $5,104,264     $-886,081    $-2,008,720    471281          .         .
   124   $8,804,805      $259,174   2942.81   $8,631,276       $85,645       $739,960   1509508          .         .
   125   $6,182,043     $-175,312   2942.81   $6,032,771     $-324,584      $-537,107    460000     496000         .
   126   $2,307,717      $-45,879   2130.33   $2,262,408      $-91,188      $-127,909    133653          .         .
   127   $3,440,776     $-142,412   2130.33   $3,348,874     $-234,313      $-436,220    245000          .         .
   128   $7,698,590     $-856,612   2942.81   $7,339,380   $-1,215,822    $-2,733,511    823439      57173         .
   129   $4,709,663     $-590,518   2130.33   $4,373,562     $-926,619    $-2,024,466    522106          .         .
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 CONGDIS  $70,952,445   $-4,066,156           $68,406,676   $-6,611,925   $-13,177,646   7333601    828173         0
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                                  ILLINOIS HOSPITAL ASSOCIATION
                              SIMULATION OF MEDICARE GAINS AND LOSSES
                             DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                     FOR SURVEYED HOSPITALS
-------------------------------------------------- CONGDIS=18 ---------------------------------------------------

    OBS   CAREDIS   HSRATE        HSCOST    RATE1      TOTREV1        DIFF1    RATE2      TOTREV2         DIFF2    RATE3

    130      700    1944.20    $1,360,940  1990.42    $1,393,294     $32,354  2138.53    $1,496,968       $51,636  2135.13
    131      800    1856.49    $1,485,192  1923.21    $1,538,567     $53,375  2090.04    $1,672,035       $93,276  2103.83
    132      500    2419.69    $1,209,845  2633.26    $1,316,632    $106,787  2992.80    $1,496,402      $214,934  3167.86
    133      566    3009.20    $1,703,151  2794.10    $1,581,459   $-121,692  2709.03    $1,533,309     $-269,953  2445.11
    134     3281    2258.13    $7,408,925  2230.87    $7,319,482    $-89,443  2311.47    $7,583,933     $-260,488  2246.34
    135     2420    2383.75    $5,768,675  2600.12    $6,292,281    $523,606  2964.85    $7,174,939    $1,048,549  3123.22
    136     5900    3542.83   $20,902,697  3473.55   $20,493,971   $-408,726  3585.00   $21,151,500   $-1,005,986  3453.74
    137     3000    3401.27   $10,203,810  3367.38   $10,102,153   $-101,657  3549.97   $10,529,913     $-286,431  3416.22
    138     6000    3900.74   $23,404,440  3745.08   $22,470,500   $-933,940  3778.39   $22,670,365   $-2,109,788  3565.77
    139     1540    1235.59    $1,902,670  1460.32    $2,248,900    $346,230  1764.42    $2,717,203      $698,432  1955.15
    140      280    1045.30      $292,740  1319.25      $369,391     $76,651  1665.93      $466,460      $156,147  1912.97
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 CONGDIS   24987             $75,643,084             $75,126,630   $-516,454            $78,493,029   $-1,669,671

    OBS        TOTREV3           DIFF3     RATE4        TOTREV4           DIFF4        TOTDIFF    CAPPASS     DMEDED    IMEDED

    130     $1,494,593         $49,261   2130.33     $1,491,229         $45,897       $179,149     166764          .         .
    131     $1,683,061        $104,302   2130.33     $1,704,262        $125,503       $376,456      85176          .         .
    132     $1,583,932        $302,465   3279.54     $1,639,768        $358,300       $982,486      45907          .         .
    133     $1,383,935       $-419,327   2130.33     $1,205,765       $-597,497    $-1,408,469      96200          .         .
    134     $7,370,229       $-474,192   2130.33     $6,989,604       $-854,817    $-1,678,941     790000          .         .
    135     $7,558,182      $1,431,791   3279.54     $7,936,476      $1,810,085     $4,814,031     420732          .         .
    136    $20,377,057     $-1,780,429   3279.54    $19,349,259     $-2,808,227    $-6,003,367    1632631    1225556    227249
    137    $10,248,672       $-567,673   3279.54     $9,838,606       $-977,738    $-1,933,499    1131000          .         .
    138    $21,394,630     $-3,385,523   3279.54    $19,677,212     $-5,102,941   $-11,532,191    2771876    7633887         0
    139     $3,010,923        $992,152   2130.33     $3,280,704      $1,261,933     $3,298,747     143296          .         .
    140       $535,631        $225,318   2130.33       $596,492        $286,178       $744,294      17030          .         .
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 CONGDIS   $76,640,845     $-3,521,855              $73,709,377     $-6,453,323   $-12,161,304    7300612    8859443    227249
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                                      ILLINOIS HOSPITAL ASSOCIATION
                                 SIMULATION OF MEDICARE GAINS AND LOSSES
                               DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                        FOR SURVEYED HOSPITALS
---------------------------------------------------- CONGDIS=19 -----------------------------------------------------

   OBS  CAREDIS   HSRATE        HSCOST     RATE1        TOTREV1         DIFF1    RATE2        TOTREV2          DIFF2     RATE3

   141    2411   3212.99    $7,746,519   3169.29     $7,641,165     $-105,354  3279.78     $7,907,554     $-319,326   3159.38
   142    2900   2312.78    $6,707,062   2265.43     $6,569,737     $-137,325  2332.56     $6,764,431     $-365,176   2225.09
   143   10229   3454.95   $35,340,684   3128.48    $32,001,264   $-3,339,420  2945.05    $30,124,963   $-7,293,046   2563.13
   144    3150   2511.15    $7,910,122   2412.78     $7,600,242     $-309,881  2436.43     $7,674,740     $-741,651   2269.95
   145    6036   2510.07   $15,150,783   2413.39    $14,567,247     $-583,536  2437.42    $14,712,279   $-1,393,002   2277.52
   146    1213   1457.16    $1,767,535   1623.71     $1,969,562      $202,027  1877.80     $2,277,772      $398,882   1997.70
   147     577   1671.46      $964,432   1787.29     $1,031,269       $66,836  1995.70     $1,151,518      $128,236   2070.79
   148     438   1959.81      $858,397   2000.70       $876,306       $17,909  2144.96       $939,492       $27,016   2131.28
   149    1005   1821.19    $1,830,296   1896.73     $1,906,218       $75,922  2071.28     $2,081,639      $136,034   2094.45
   150    1100   2034.68    $2,238,148   2056.85     $2,262,537       $24,389  2184.75     $2,403,227       $24,076   2151.18
   151    1128   1926.26    $2,172,821   1979.82     $2,233,241       $60,419  2132.75     $2,405,737      $102,481   2146.38
   152    2300   2234.86    $5,140,178   2211.99     $5,087,572      $-52,606  2297.25     $5,283,680     $-162,904   2232.16
   153    1065   1958.41    $2,085,707   2003.94     $2,134,192       $48,485  2149.79     $2,289,522       $78,610   2154.90
   154    1248   1582.87    $1,975,422   1719.42     $2,145,840      $170,418  1946.66     $2,429,429      $331,512   2039.20
   155     518   2113.39    $1,094,736   2120.89     $1,098,619        $3,883  2232.90     $1,156,641       $-3,353   2199.98
   156    3710   2596.06    $9,631,383   2704.66    $10,034,284      $402,901  2949.67    $10,943,277      $705,118   2984.79
   157    2300   3258.78    $7,495,194   3207.51     $7,377,270     $-117,924  3308.48     $7,609,499     $-335,632   3192.72
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CONGDIS  41328            $110,109,418             $106,536,562   $-3,572,856           $108,155,400   $-8,682,104

   OBS        TOTREV3          DIFF3     RATE4        TOTREV4           DIFF4         TOTDIFF     CAPPASS   DMEDED   IMEDED

   141     $7,617,211      $-609,669   3037.03     $7,322,283       $-904,597    $-1,938,947      650000        .        .
   142     $6,452,748      $-676,859   2130.33     $6,177,949       $-951,658    $-2,131,018      666258        .        .
   143    $26,218,240   $-11,199,769   2130.33    $21,791,118    $-15,626,891   $-37,459,125     2982279   470833        .
   144     $7,150,345    $-1,266,025   2130.33     $6,710,531     $-1,705,839    $-4,023,376     1359800        .        .
   145    $13,747,082    $-2,358,200   2130.33    $12,858,655     $-3,246,626    $-7,581,364      800000        .        .
   146     $2,423,216       $544,326   2130.33     $2,584,087        $705,197     $1,850,432       67123        .        .
   147     $1,194,843       $171,561   2130.33     $1,229,199        $205,917       $572,551       35774        .        .
   148       $933,502        $21,026   2130.33       $933,083         $20,608        $86,560       21958        .        .
   149     $2,104,918       $159,313   2130.33     $2,140,979        $195,374       $566,643       70200        .        .
   150     $2,366,298       $-12,853   2130.33     $2,343,360        $-35,791          $-179       79502        .        .
   151     $2,421,111       $117,855   2130.33     $2,403,009         $99,753       $380,509      359635        .        .
   152     $5,133,971      $-312,613   2130.33     $4,899,753       $-546,831    $-1,074,955     1650000    25000        .
   153     $2,294,963        $84,052   2130.33     $2,268,799         $57,887       $269,034      178000        .        .
   154     $2,544,921       $447,003   2130.33     $2,658,648        $560,731     $1,509,664      107980        .        .
   155     $1,139,591       $-20,402   2130.33     $1,103,510        $-56,484       $-76,356      172764        .        .
   156    $11,073,582       $835,422   3037.03    $11,267,387      $1,029,228     $2,972,668     2877463   130848        0
   157     $7,343,264      $-601,866   3037.03     $6,985,173       $-959,958    $-2,015,380      896100    86600    38400
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CONGDIS  $102,159,808   $-14,677,697              $95,677,523    $-21,159,982   $-48,092,639    12974836   713281    38400
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                              ILLINOIS HOSPITAL ASSOCIATION
                        SIMULATION OF MEDICARE GAINS AND LOSSES
                       DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                FOR SURVEYED HOSPITALS
--------------------------------------------------------- CONGDIS=20 --------------------------------------------------------

  OBS   CAREDIS   HSRATE         HSCOST     RATE1        TOTREV1       DIFF1     RATE2        TOTREV2          DIFF2     RATE3

  158      949   2345.70     $2,226,069   2289.40     $2,172,643    $-53,427   2349.23     $2,229,422     $-138,003   2229.89
  159      464   1586.70       $736,229   1719.44       $797,819     $61,590   1944.62       $902,303      $118,955   2024.05
  160     4300   2286.25     $9,830,875   2456.89    $10,564,638    $733,763   2747.34    $11,813,576    $1,404,842   2877.48
  161     5000   2832.91    $14,164,550   2858.43    $14,292,165    $127,615   3026.11    $15,130,547       $73,630   2975.35
  162     1159   2474.96     $2,668,479   2575.91     $2,985,475    $116,997   2822.45     $3,271,219      $222,026   2860.59
  163     2195   2004.33     $4,399,504   2034.09     $4,464,826     $65,321   2168.62     $4,760,124       $83,450   2143.11
  164     1081   2149.94     $2,324,085   2147.58     $2,321,538    $-2,548    2251.30     $2,433,655      $-29,945   2205.65
  165      960   2120.16     $2,035,354   2127.39     $2,042,296      $6,942   2238.43     $2,148,893       $-6,099   2209.82
  166     3800   2379.06     $9,040,428   2459.61     $9,346,506    $306,078   2663.06    $10,119,626      $547,802   2704.64
  167     2950   3136.00     $9,251,200   2887.13     $8,517,028   $-734,172   2773.93     $8,183,082   $-1,623,468   2466.97
  168      917   2733.99     $2,507,069   2579.91     $2,365,773   $-141,296   2554.98     $2,342,913     $-324,608   2329.23
  169     7618   3303.57    $25,166,596   3312.30    $25,233,083     $66,486   3477.38    $26,490,666     $-155,222   3430.08
  170     9200   3057.36    $28,127,712   3118.19    $28,687,332    $559,620   3334.93    $30,681,362      $781,604   3312.46
  171     1244   2808.82     $3,494,172   2929.68     $3,644,525    $150,353   3200.11     $3,980,939      $263,140   3234.74
  172      889   2342.91     $2,082,847   2288.02     $2,034,053    $-48,794   2348.58     $2,087,885     $-126,182   2233.09
  173     2042   2769.18     $5,654,666   2607.73     $5,324,978   $-329,688   2575.14     $5,258,434     $-752,476   2346.37
  174      490   1996.67       $958,402   2032.63       $975,663     $17,261   2170.06     $1,041,631       $25,676   2165.03
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CONGDIS  45248              $124,868,236             $125,770,340    $902,104              $132,876,275      $365,144

  OBS         TOTREV3          DIFF3     RATE4       TOTREV4         DIFF4        TOTDIFF    CAPPASS    DMEDED    IMEDED

  158      $2,116,163     $-251,261    2130.33    $2,021,681     $-345,744      $-788,435     101862         .         .
  159        $939,158      $155,810    2130.33      $988,472      $205,124       $541,480      26271         .         .
  160     $12,373,172    $1,964,438    2941.19   $12,647,119    $2,238,385     $6,341,428      49711         0         0
  161     $14,876,731     $-180,186    2941.19   $14,705,952     $-350,964      $-329,905     506000     64000     20000
  162      $3,315,424      $266,231    2915.20    $3,378,716      $329,524       $934,778     178366         .         .
  163      $4,704,137       $27,464    2130.33    $4,676,068         $-605       $175,631     276317         .         .
  164      $2,384,310      $-79,290    2130.33    $2,302,884     $-160,716      $-272,499     143834         .         .
  165      $2,121,424      $-33,568    2130.33    $2,045,114     $-109,878      $-142,602     113545         .         .
  166     $10,277,636      $705,812    2685.23   $10,203,863      $632,039     $2,191,731    1147380    487344     48984
  167      $7,277,547   $-2,529,002    2130.33    $6,284,465   $-3,522,084    $-8,408,726    1118000     80000     51000
  168      $2,135,901     $-531,621    2130.33    $1,953,510     $-714,011    $-1,711,536      93102         .         .
  169     $26,130,314     $-515,574    3308.54   $25,204,481   $-1,441,408    $-2,045,718    1866150   1879566         .
  170     $30,474,615      $574,857    3308.54   $30,438,596      $538,838     $2,454,919    2280000   1635000   1000000
  171      $4,024,016      $306,216    3308.54    $4,115,828      $398,028     $1,117,739      96373         .         .
  172      $1,985,219     $-228,847    2130.33    $1,893,861     $-320,205      $-724,028     181623         .         .
  173      $4,791,295   $-1,219,614    2130.33    $4,350,128   $-1,660,781    $-3,962,559     189049         .         .
  174      $1,039,216       $23,282    2130.33    $1,022,557        $6,623        $72,862      50000         .         .
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CONGDIS  $130,966,278   $-1,544,854              $128,233,296   $-4,277,835    $-4,555,441    8862583   4145910   1119984
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                                   ILLINOIS HOSPITAL ASSOCIATION
                             SIMULATION OF MEDICARE GAINS AND LOSSES
                           DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                      FOR SURVEYED HOSPITALS
--------------------------------------------------------- CONGDIS=21 -------------------------------------------------------

   OBS  CAREDIS   HSRATE        HSCOST     RATE1       TOTREV1        DIFF1     RATE2       TOTREV2         DIFF2     RATE3

   175    2500   3420.75    $8,551,875   3290.78    $8,226,957    $-324,918   3331.04    $8,327,592     $-737,652   3142.33
   176    2080   2347.10    $4,881,968   2485.55    $5,169,934     $287,966   2761.99    $5,744,932      $569,899   2857.81
   177    1389   3517.44    $4,885,724   3357.77    $4,663,937    $-221,787   3376.53    $4,689,997     $-503,528   3137.63
   178    4878   2775.57   $13,539,230   2814.45   $13,728,865     $189,635   2961.36   $14,445,495       $93,504   2930.47
   179    6600   2961.99   $19,549,134   2948.67   $19,461,235     $-87,899   3053.77   $20,154,877     $-625,853   2949.70
   180    1150   2660.46    $3,059,529   2722.52    $3,130,903      $71,374   2893.51    $3,327,532       $75,253   2869.57
   181    1200   2793.19    $3,351,828   2850.57    $3,420,683      $68,855   3052.04    $3,662,446       $96,101   3026.47
   182     423   3877.08    $1,640,005   3638.72    $1,539,177    $-100,828   3543.50    $1,498,898     $-241,180   3212.55
   183    2561   2532.10    $6,484,708   2631.84    $6,740,150     $255,442   2832.31    $7,253,554      $379,569   2865.95
   184    3450   3738.11   $12,896,479   3528.80   $12,174,370    $-722,110   3499.24   $12,072,387   $-1,598,268   3226.44
   185     900   1556.59    $1,400,931   1702.57    $1,532,314     $131,383   1936.82    $1,743,134      $258,105   2048.41
   186    1250   3408.54    $4,260,675   3276.09    $4,095,114    $-165,561   3318.65    $4,148,309     $-380,788   3108.69
   187    1010   1778.21    $1,795,992   1864.50    $1,883,144      $87,152   2048.44    $2,068,923      $159,783   2083.02
   188    1872   2488.97    $4,659,352   2591.95    $4,852,126     $192,774   2837.18    $5,311,200      $372,147   2895.40
   189    1697   2984.36    $5,064,459   2959.80    $5,022,782     $-41,677   3095.38    $5,252,857     $-125,649   3006.20
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CONGDIS  32960             $96,021,890             $95,641,691    $-380,199             $99,702,133   $-2,208,556

   OBS        TOTREV3          DIFF3     RATE4       TOTREV4          DIFF4          TOTDIFF    CAPPASS   DMEDED   IMEDED

   175     $7,855,832    $-1,209,412   2915.20    $7,287,999    $-1,777,245     $-4,049,227     375000        .        .
   176     $5,944,240       $769,207   2915.20    $6,063,615       $888,583      $2,515,655    2447000        .        .
   177     $4,358,167      $-835,358   2915.20    $4,049,212    $-1,144,312     $-2,704,985     579020        .        .
   178    $14,294,856       $-57,134   2861.83   $13,959,985      $-392,005       $-166,000     179418    25000        0
   179    $19,468,048    $-1,312,681   2861.83   $18,888,049    $-1,892,680     $-3,919,113    1687307   129005    71535
   180     $3,300,009        $47,729   2861.83    $3,291,099        $38,820        $233,176     258440        .        .
   181     $3,631,761        $65,416   3037.03    $3,644,438        $78,093        $308,465     990170        0        0
   182     $1,358,909      $-381,168   2861.83    $1,210,552      $-529,526     $-1,252,702      34826        .        .
   183     $7,339,707       $465,722   2861.83    $7,329,135       $455,150      $1,555,883     286830        .        .
   184    $11,131,203    $-2,539,453   2915.20   $10,057,439    $-3,613,216     $-8,473,047    1649214        .        .
   185     $1,843,569       $358,540   2130.33    $1,917,295       $432,266      $1,180,293     106600        .        .
   186     $3,885,861      $-643,237   2915.20    $3,644,000      $-885,098     $-2,074,684     223740        .        .
   187     $2,103,854       $194,714   2130.33    $2,151,631       $242,491        $684,140     113287        .        .
   188     $5,420,196       $481,144   2915.20    $5,457,254       $518,201      $1,564,267     439396        .        .
   189     $5,101,528      $-276,978   2915.20    $4,947,094      $-431,412       $-875,716     164859        .        .
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CONGDIS   $97,037,739    $-4,872,949             $93,898,797    $-8,011,892    $-15,473,595    9535087   154005    71535
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                                       ILLINOIS HOSPITAL ASSOCIATION
                                 SIMULATION OF MEDICARE GAINS AND LOSSES
                               DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                                          FOR SURVEYED HOSPITALS
)------------------------------------------------------ CONGDIS=22 ------------------------------------------------------

    OBS  LAKEDIS   HSRATE       HSCOST    RATE1      TOTREV1        DIFF1    RATE2      TOTREV2        DIFF2    RATE3

    190      700  2327.63   $1,629,341  2276.56   $1,593,595     $-35,746  2340.46   $1,638,319     $-93,671  2229.03
    191     2276  2623.39   $5,970,836  2500.53   $5,691,200    $-279,635  2499.94   $5,689,056    $-648,246  2319.37
    192      825  2615.25   $2,157,581  2492.28   $2,056,130    $-101,451  2493.33   $2,056,993    $-236,516  2305.47
    193      636  3040.03   $1,933,459  3009.06   $1,913,765     $-19,694  3097.34   $1,969,908     $-83,445  2980.48
    194     1084  2241.92   $2,430,241  2212.28   $2,398,113     $-32,128  2294.90   $2,487,672     $-95,675  2206.25
    195     1988  2674.55   $5,317,005  2538.90   $5,047,328    $-269,677  2527.09   $5,023,855    $-620,199  2332.95
    196     2356  2224.97   $5,242,029  2201.00   $5,185,551     $-56,478  2287.62   $5,389,624    $-177,463  2209.68
    197     1049  2340.11   $2,454,775  2288.07   $2,400,183     $-54,593  2349.58   $2,464,714    $-141,054  2244.20
    198     2464  2928.54   $7,215,923  2727.25   $6,719,936    $-495,987  2659.84   $6,553,843  $-1,116,683  2388.72
    199     1388  1918.48   $2,662,850  1969.70   $2,733,946      $71,096  2122.99   $2,946,713     $116,103  2120.30
    200      718  2220.66   $1,594,434  2197.77   $1,577,996     $-16,438  2285.33   $1,640,865     $-52,439  2208.53
    201      907  1968.88   $1,785,774  2008.93   $1,822,100      $36,326  2151.63   $1,951,530      $55,020  2141.69
    202      408  2827.78   $1,153,734  2651.68   $1,081,884     $-71,850  2606.28   $1,063,364    $-163,055  2361.95
    203      585  2310.26   $1,351,502  2265.68   $1,325,423     $-26,079  2333.74   $1,365,239     $-69,394  2236.27
    204     1232  2199.34   $2,709,587  2182.49   $2,688,828     $-20,759  2274.87   $2,802,640     $-73,614  2206.84
    205      731  2287.33   $1,672,038  2246.34   $1,642,074     $-29,964  2319.04   $1,695,215     $-82,162  2218.32
    206      944  1998.19   $1,886,291  2029.48   $1,915,833      $29,542  2165.36   $2,044,098      $38,970  2141.48
    207     1249  2357.20   $2,944,143  2298.74   $2,871,128     $-73,015  2356.17   $2,942,858    $-186,765  2236.89
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CONGDIS    21540           $52,111,545           $50,665,012  $-1,446,532           $51,727,307  $-3,630,288
          ======           ===========           ===========  ===========           ===========  ===========
          533387            1883190647            1821706191 $-61,484,457            1849981358   -148763026

    OBS      TOTREV3        DIFF3    RATE4      TOTREV4        DIFF4        TOTDIFF    CAPPASS    DMEDED    IMEDED

    190   $1,560,322    $-171,667  2130.33   $1,491,229    $-240,760      $-541,845     277502         .         .
    191   $5,278,890  $-1,059,212  2130.33   $4,848,625  $-1,489,477    $-3,476,570     746162    186496    116349
    192   $1,902,010    $-391,499  2130.33   $1,757,520    $-535,989    $-1,265,454     105457         .         .
    193   $1,895,586    $-157,766  2861.83   $1,820,121    $-233,232      $-494,137      38087         .         .
    194   $2,391,580    $-191,767  2130.33   $2,309,275    $-274,072      $-593,641     240955         .         .
    195   $4,637,901  $-1,006,153  2130.33   $4,235,091  $-1,408,964    $-3,304,993     312074         .         .
    196   $5,206,002    $-361,085  2130.33   $5,019,051    $-548,037    $-1,143,063     205895         .         .
    197   $2,354,161    $-251,608  2130.33   $2,234,713    $-371,055      $-818,310     195000         .         .
    198   $5,885,815  $-1,784,711  2130.33   $5,249,126  $-2,421,399    $-5,818,780    1030226         .         .
    199   $2,942,977     $112,367  2130.33   $2,956,894     $126,284       $425,850     128420         .         .
    200   $1,585,728    $-107,577  2130.33   $1,529,575    $-163,730      $-340,185      54100         .         .
    201   $1,942,509      $45,999  2130.33   $1,932,207      $35,697       $173,041     148018         .         .
    202     $963,674    $-262,745  2130.33     $869,174    $-357,246      $-854,897     200000         .         .
    203   $1,308,220    $-126,413  2130.33   $1,246,241    $-188,392      $-410,278      71812         .         .
    204   $2,718,825    $-157,429  2130.33   $2,624,563    $-251,690      $-503,492     113158         .         .
    205   $1,621,593    $-155,783  2130.33   $1,557,269    $-220,107      $-488,016     166417         .         .
    206   $2,021,560      $16,432  2130.33   $2,011,029       $5,901        $90,845     155672         .         .
    207   $2,793,876    $-335,748  2130.33   $2,660,779    $-468,845    $-1,064,373     119922         .         .
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CONGDIS  $49,011,230  $-6,346,364           $46,352,482  $-9,005,112   $-20,428,296    4308877    186496    116349
         ===========  ===========           ===========  ===========   ============  =========  ========  ========
          1748623548   -250120836            1638265505   -360478880     -820847199  211375342  82991932  29877946
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              ILLINOIS HOSPITAL ASSOCIATION
        SIMULATION OF MEDICARE GAINS AND LOSSES
       DUE TO IMPLEMENTATION OF NATIONAL PPS RATE
                FOR SURVEYED HOSPITALS

          VARIABLE          N          SUM

          CAREDIS         207        533387.00
          HSCOST          207    1883190647.32
          TOTREV1         207    1821706190.79
          DIFF1           207     -61484456.53
          TOTREV2         207    1849981357.91
          DIFF2           207    -148763026.42
          TOTREV3         207    1748623547.96
          DIFF3           207    -250120836.37
          TOTREV4         207    1638265504.80
          DIFF4           207    -360478879.53
          CAPPASS         206     211375342.00
          DMEDED           73      82991932.00
          IMEDED           50      29877946.00
          DIF4PASS        206    -328514366.75
          TOTDIFF         207    -820847198.85
          CAPPASSA        206     845501368.00
          DMEDALL          44     289164836.00
          IMEDALL          44     115720628.00
          TOTDIFFP        206    -711254095.92
          CAREREV         207    2121041433.00
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                                        ILLINOIS HOSPITAL ASSOCIATION
                                         ESTIMATED STATEWIDE IMPACT
                                     OF IMPLEMENTATION OF NATIONAL PPS RATE
                                           FOR SURVEYED HOSPITALS

OBS    WEIGHT       ALLCOST          ALLREV1         ALLDIFF1         ALLREV2          ALLDIFF2         ALLREV3          ALLDIFF3

 1    0.930908  $2,022,961,823  $1,956,913,965   $-66,047,858   $1,987,287,727   $-159,804,279   $1,878,407,099   $-268,684,907

OBS    ALLREV4        ALLDIFF4        ALLCAP4        ALDIFF4P         ALLDIFF          ALLCAP         ALLDIFFP        ALLDMED4     ALLIMED4

 1  $1,759,858,237 $-387,233,769 $227,063,706 $-352,896,837 $-881,770,812 $908,254,823 $-764,043,664 $93,234,584 $33,565,406
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Chairman STARK. If the gentleman would yield, we will hear some testimony in a while that would indicate——

Mr. DAUB. California testimony?

Chairman STARK. Yes.

Mr. DAUB. Yes.

Chairman STARK. That Illinois' drop is $77 million, 3½ percent drop. Where that is——

Mr. PORTER. Has the Illinois Hospital Association testified yet this morning? They will be testifying, so you might ask them that question, but if they do not have the information, I can get that.

Mr. DAUB. Thank you very much. That is all, Mr. Chairman.

Chairman STARK. Mr. Gregg.

Mr. GREGG. No questions.

Chairman STARK. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Chairman STARK. John, thank you. I sincerely want to indicate this is an issue the committee would like to study. I just think we feel very frustrated in having to say let's pick a number out of the air, and everybody above it benefits, everybody below it loses it. If we had a way to explain it or had the information we would like, I think you can appreciate we would feel much more comfortable we were doing the right thing. I hope you will help us obtain that information.

Mr. PORTER. Mr. Chairman, all I can say is at the rate we are going, you will get the information after we are $300 million out of pocket instead of $78 million. So let's hold it where it is.

Chairman STARK. I share your concern.

Mr. PORTER. Thank you, Mr. Chairman.

STATEMENT OF JACK W. OWENS, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Chairman STARK. Mr. Jack Owen, executive vice president, American Hospital Association.

Mr. OWEN. Thank you.

Chairman STARK. Before you begin, I would like to thank you, Mr. Owen. We had asked the witnesses to get their testimony early for the convenience of the staff and members. I would say those of you who did get your testimony in by the requested time, we appreciate it very much. Those of you who were for one reason or another unable to have your testimony in on time, I hope you will understand that this committee is becoming obsessed with timeliness of information. We do appreciate those of you who try to meet our time constraints. We will try to notice you as early as possible. Proceed.

Mr. OWEN. Several weeks ago, I met with you, and you asked me for a list of hospitals that were disproportionate share providers. I told you at that time that we had the information, but I had to get clearance from the hospitals. I have those lists and will give them to you right now.

Chairman STARK. Is this what we would refer to as the sanitized list? No. It has the names of the hospitals.

Mr. OWEN. Yes, sir.

Chairman STARK. So it cannot be made public.

Mr. **Owen**. I would prefer they be handled in executive session.

Chairman **Stark**. That was our understanding with you. I would ask unanimous consent that the committee will keep this information confidential to be shared only by its members and staff and used at such time as we have a closed hearing. Without objection. I deeply appreciate your sharing that information with us.

Mr. **Owen**. There are two lists there, one with a list of hospitals for which about 13.7 percent of their revenue or estimated revenue would come from Medicaid and charity care and bad debt, which ties into what Mr. Dobson said. He said 11 percent on Medicaid.

The other is a little higher group, which is 20 percent, which is what CBO is using as a definition of disproportionate. The 13.7 is the mean we have in hospitals.

Chairman **Stark**. Thank you very much.

Mr. **Owen**. Now, to my reason for being here today. As I listened to the comments, I would be hopeful that as the discussions took place on the transition and on the recalculation and on the waiting, that we are going ahead—as we had hoped to proceed when we started this program—which means, in effect, that we would be moving toward market basket plus a quarter percent for technology.

However, as you stated, Mr. Chairman, that is not going to be the case. We are going to be faced with a problem of cutback, a freeze possibly, I would like to direct my remarks to what we think is necessary should such an action be required. We feel strongly that the hospitals have delivered on their part of the bargain in the past 3 years, whether 75-25 or 50-50. The results are that actions took place, and those results are good.

But we anticipated that we would go forward with a market basket. Without that, there will be problems in the system. What I would like to do is to take my 3 or 4 minutes and just summarize what I think needs to be done if this committee does not see its way toward giving at least 2 or 3 percent "plus technology" to hospitals in 1986.

First of all, we feel strongly that any action should be legislative, that it should not be regulatory; that if Congress is going to have a freeze, if Congress is going to cut back, then a regulatory agency should not carry it out as it sees fit. I think it has to be done in this committee; that is where it belongs.

Second, I would say if we have to have such a freeze, then please be sure it is only for 1 year and that we go back onto the inflation update schedule we are on. A freeze is going to create hardships in many of our hospitals. If quality and care and access are going to be maintained, it must be clear to those hospitals that are in the system that a freeze will only be for 1 year and that the beneficiaries and the hospitals will then move back into the stream of what we started out to. We support the prospective payment system as it now exists.

Third, there has got to be a correction of the wage index to take place before the freeze becomes effective. The wage index has been inaccurate since the program started. Data have been available to HHS since December 1984. This is a budget neutral process. It will not add expense to the Medicare trust fund. It should be corrected promptly so the price freeze does not carry these inequities forward for another year.

I was pleased to hear Congressman Daub say he was ready to move forward with legislation on this. We would certainly support him and support the concept of removing the retroactive feature in getting the correction quickly. We would support that.

Fourth, we feel a hold harmless clause must be placed in any kind of legislation which would assure all the hospitals that the price they are going to be paid per DRG is not less than the 1985 DRG rate. They need to go into 1986 knowing that that price is the same. If there isn't such a clause, then hospitals are going to be faced with recalibration, they are going to be faced with wage changes.

We heard Dr. Davis state this morning that HCFA wants to cut back through regulations that are coming out. We won't be faced with a freeze if that occurs, we will be faced with a cut. I don't think that Congress intends that. Certainly that will put the hospitals in bigger jeopardy than they can live with. That would, in effect, slow down the transition. Again, we are saying that if there is a freeze, then that means that the plan Congress had for moving toward a national rate comes to a grinding halt, because as we are moving toward a national rate, we expected to move forward with a market basket plus a technological adjustment. Without that, we are talking about a whole different ball game, and I think that is what the freeze ought to be all about, when it comes to the transition, not a question of 50-50 or 75-25, but the fact that if a hospital was paid a price in 1975, it should get that same price in 1986.

Fifth, we think that the equity issues have to be addressed. We have heard lots of talk this morning about the reports that are necessary, the problem of urban-rural pricing; the problem of the indirect medical education factor. All of these must be corrected and should be corrected during any time that we have a pause if that occurs. If we don't have a pause, then we should move forward and correct these right away.

Last, we think that this committee should look at the disproportionate share hospitals and do something about them because the problem is there. Congressman Rangel pointed it out very well this morning. We know there are some problems in our inner city hospitals. We know that there are a number of hospitals that are facing a difficult time. What the Department comes up with as to how the dollars will be distributed still remains to be seen, but we think it is necessary that this committee move forward and require that something be done to help these hospitals.

With that, I would close, Mr. Chairman, and answer any questions that you might have. My testimony has been submitted, as you already mentioned.

[The prepared statement follows:]

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

SUMMARY

As Congress considers a freeze on Medicare hospital payments, the American Hospital Association (AHA) believes that the following prospective pricing system issues must be taken into account:

A freeze should result from legislative action, not regulatory fiat.

A freeze should be only for one year, followed by an increase of the hospital marketbasket plus one-quarter of a percentage point, as now provided for in law.

Correction of the area wage index should take place before a freeze would become effective.

Hospitals should be assured that they would be paid no less in FY 1986 than they were in FY 1985.

Equity issues in the prospective pricing system should be addressed during the freeze period.

An adjustment for hospitals providing care to disproportionate numbers of low-income patients should be granted.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president of the AHA. The Association represents over 6,100 member hospitals and health care institutions that annually provide services to more than 10 million Medicare beneficiaries. The Association also includes approximately 38,000 personal members. I am pleased to have this opportunit to continue the dialogue on Medicare prospective pricing.

Prospective pricing represents a dramatic, and constructive, change in Medicare payment policies. The strong, positive responses of hospitals to the incentives created by the new system demonstrate that economic incentives are more effective than regulatory controls in containing health costs.

Although all acute-care hospitals that participate in Medicare now are paid under prospective pricing, the task of implementing the system is far from complete. As hospitals have entered the system, they have confirmed the existence of problems that both were anticipated and unsuspected when the plan was designed.

In developing the system, Congress wisely included a three-year transition period, during which time problems could be identified and resolved before doing serious damage to the nation's hospital network. This hearing, occurring at this time, is an important step toward the goal of achieving an equitable prospective pricing system.

The subcommittee has requested comments on several topics:

The impact of the movement toward uniform average rates of payment;

The relationship between the so-called indirect graduate medical education factor and the ability of diagnosis-related group (DRGs) to measure severity of illness;

The implementation of a more accurate area wage index; and

The need for a "disproportionate share" adjustment to recognize the higher costs of treating Medicare patients associated with a high volume of low-income patients.

These issues, most of which are closely related, seem to center on two fundamental questions: First, does the current system of DRGs adequately recognize differences in the types of patients treated in different hospitals? Second, does the current method of setting prices accurately reflect the cost of treating the "average" patient in each DRG?

To the extent that the answer to each question is "no," the prospective pricing system will fail to reward or penalize hospitals based on their degrees of efficiency. Instead, it will base gains and lossels on the biases inherent in the DRG structure or price-setting method. While the AHA views the system as biased against certain groups of hospitals, it believes that the problems can be corrected in time, as better data is collected and better DRGs and price-setting developed. As the Association indicated when prospective pricing legislation was considered by Congress, the AHA is committed to a fair, workable prospective pricing system. Therefore, it is dedicated to the early correction of problems with the system.

JURISDICTIONAL AND DATA CONCERNS

Prior to commenting on the transition to uniform rates, relationship between the indirect medical education factor and severity of illness, area wage index, and disproportionate share adjustment, I would like to address Association concerns regarding congressional jurisdiction over prospective pricing issues and availability of data on the impact of the system on hospitals.

The first concern is the intent, first expressed in FY 1986 budget documents, of the Department of Health Human Services (HHS) to freeze hospital DRG rates and certain other payments—such as those for direct medical education—by regulatory action. The Association believes that such actions should result from legislative, rather than regulatory, action, and sees this Subcommittee, as well as its counterpart in the other body, as a forum for discussion of such initiatives.

The second concern is the difficulty of assessing the impact of prospective pricing on hospitals. Many hospitals have not yet completed a full cost-reporting year under the system. Even those hospitals that have finished their first year have not yet filed Medicare cost reports. Consequently, it is impossible to assess the extent to which Medicare prospective pricing has affected their overall financial performance. Moreover, hospitals' experience during their first federal fiscal year under prospective pricing is of limited value in anticipating the impact on them once the system is fully implemented.

However, the AHA has examined intensively the data that are currently available, basically the data used to establish prospective prices during the first and second years. Although these data admittedly are not as current as would be desirable, they do indicate the "general pattern of impact" that will occur.

The Association is eager to update its analysis, using more current information once the data are made available by HHS' Health Care Financing Administration (HCFA). The use of timely data would be particularly valuable because the decisions made during the next several months will affect prospective pricing's third year. It seems, however, that more current data will yield results that generally are consistent with results obtained from use of the older data.

EFFECTS OF THE TRANSITION TOWARD UNIFORM RATES

The transition to uniform prices based on average cost-per-case in urban and rural areas highlights the defects of the DRG system, as well as the limitations of the current price-setting method. The AHA analysis has identified several significant patterns, some of which were expected.

One finding is that hospitals that treat the most complex mix of patients are more likely to experience losses of revenue than hospitals that care for a less complex mix of patients. This finding implies that payments for DRGs with above average prices do not, in general, cover the costs of the services needed by patients in those DRGs.

The inability of DRGs to reflect differences of severity of illness has been widely discussed, and is currently the subject of several research studies sponsored by HCFA. This limitation led to the "doubling" of the so-called "indirect medical education factor" when Congress drafted prospective pricing legislation. Even with the doubled "indirect education" factor, however, there is evidence that the system is biased against high-cost DRGs. In fact, the entire system appears to discriminate against patients requiring the most intensive treatment.

Another finding is that large hospitals are more likely to experience significant losses of revenue—compared to the revenues that they would have received under cost-based reimbursement—than small hospitals. This is particularly true in rural areas. It seems that many of the largest rural hospitals, despite the doubling of the "indirect edcuation factor," are more likely than non-teaching hospitals to experience losses of revenue.

An additional finding is that small, rural hospitals are more likely to experience either a substantial gain or a substantial loss than larger rural hospitals. The reasons for this polarization are unknown, suggesting a need for further research into the effects of prospective pricing on rural hospitals. This need is reinforced by the recent substantial decline in the number of admissions and inpatient census of rural hospitals, a decline that has caused a significant deterioration in the financial position of many rural hospitals.

Although individual hospitals have experienced problems, these problems generally have been limited to the specific circumstances of each hospital, with most system-wide problems difficult to detect. As hospitals move through the second year and into the third year of prospective pricing, system-wide problems are expected to become more apparent.

The transition to uniform prices is expected to exacerbate existing problems, leading to disproportionate losses of revenue for hospitals that are struggling under the system, particularly those with complex case mixes.

INDIRECT MEDICAL EDUCATION FACTOR AND SEVERITY OF ILLNESS

Henry Desmarais of HCFA stated in congressional testimony on April 3 that "it is hard to justify" doubling of the indirect medical education factor. The AHA believes there are several justifications for doubling the factor.

The primary purpose of the indirect medical education factor, a more appropriate name for which would be "patient severity adjustment," is to adjust for differences in patient severity that are not captured by the system of DRGs. The doubling resulted from Congress recognition, in drafting prospective pricing, that teaching hospitals would be severely penalized under a system of uniform pricing that relied on the "single" education adjustment. Even with the doubled factor, teaching hospitals—more significantly hospitals that treat more complex patients—are more likely to experience substantial reductions in revenues under prospective pricing. Reducing the factor by half, as has been proposed by HHS, would increase seriously the likelihood of substantial losses for hospitals that treat the most complexly ill Medicare patients.

The AHA realizes that the current method of recognizing severity is far from optimal. By labeling legitimate patient-related costs as "educational" costs, the current policy has created an attractive target for budget cutters. In addition, the manner, which is not consistent with the analysis on which the factor is based, in which HCFA has implemented the adjustment may have led to slight overpayments for hospitals with relatively large graduate medical educational programs and slight underpayments to hospitals with smaller programs. An alternative is clearly needed, one that addresses the fundamental problem of recognizing differences in the types of patients treated in different hospitals. Simply reducing the factor would cut payments to all hositals without addressing this issue.

AREA WAGE INDEX

Imperfections in the system of DRGs and the setting of prices are not the only sources of inequities. The original design for the prospective pricing system calls for an adjustment to the prices to reflect the level of wages prevailing in the labor market in which each hospital is located. This adjustment is made using a wage index that is intended to reflect the difference between the average wage of hospital employees located in each area and the average wage of hospital employees nationally. For this adjustment to achieve the goal of the legislation, two elements are necessary:

The areas for which indexes are computed must coincide with the actual boundaries of hospital labor markets, and

The index values must reflect differences in average hourly compensation of hospitals employees in each area.

The index currently used by HCFA meets neither of these criteria. The data on which the index is based reflect average compensation per employee, as they are intended for use in unemployment insurance programs. As a result, variations in the mix of full- and part-time employees can cause differences in the wage adjustment for an area that are not related to differences in the hourly wage of hospital employees. Even more seriously, the areas used to compute the index, Metropolitan Statistical Areas (MSAs), are not intended to represent hospital labor markets. The problems such flaws create are particularly acute in rural areas, because of the assumption that all rural hospitals in a state compete for employees in the same labor market, desite the fact that they are located hundreds of miles apart and often compete with neighboring urban hospitals with widely varying wage levels.

For several years, industry groups have been concerned with the limitations of the HCFA index. During the first prospective pricing year, HCFA acknowledged the limitations of the current wage index and convened and advisory group to examine alternatives to it. Eventually, HCFA determined that it would be necessary to collect new data that would enable it to identify the actual hourly wage prevailing in each area. A survey of all hospitals was conducted, to which over 90 percent responded. More significantly, the data submitted by the hospitals were reviewed by fiscal intermediaries and reverified by the facilities themselves. A sample of the data was audited by the HHS Inspector General and found to be accurate. In short, these data have been subjected to greater scrutiny than those previously used to compute the wage index.

HCFA has submitted its report on the new index to Congress. The report confirms that the old index seriously misrepresents the level of wages prevailing in several areas, particularly in rural areas. The report also documents that inaccuracies in the current index have led to overpayments and underpayments in some areas. The report documents two further issues, although these issues are not discussed widely.

First, the amounts of any overpayments and underpayments that have resulted from the use of an inaccurate index during the first two prospective pricing years will be doubled during the third prospective pricing year. Because the payments were based on a 25-percent hospital-specific/75-percent federal blend in the first year, and a 50-percent hospital-specific 50-percent federal blend in the second year, the impact of errors in the wage index has been minimized so far. However, any failure to correct the problem will create substantial difficulties for many hospitals and in many areas. The sooner the problem can be corrected, the less disruptive the adoption of the new index will be.

Second, the report to Congress demonstrates that many areas will experience a significant change in prices even if the new HCFA index is not adopted. HCFA has routinely updated the area wage index when new Bureau of Labor Statistics (BLS) data have become available. Moving to the 1982 BLS index will result in significant changes for many areas, possibly due to changes in the mix of full- and part-time employees. Until the area wage adjustment is put on a sound basis through the use of verified data reflecting hourly wages, these shifts will continue.

It should be noted the HCFA has yet to address the adequacy of MSAs as defintions of hospital labor markets. Several rural hospitals, surrounded by urban areas, have reported significant difficulties arising from a wage adjustment that is substantially lower than that received by neighboring urban hospitals. The AHA has urged HCFA to undertake the research necessary to create more equitable labor market definitions, and is planning to use the new wage data to explore several alternatives. It is important that this issue be addressed, even after the problems with the BLS data are resolved.

The controversy surrounding the area wage adjustment demonstrates the critical need for accurate and reliable data in a pricing system based on uniform average rates.

DISPROPORTIONATE SHARE ADJUSTMENT

Another issue that has received considerable attention from both Congress and hospitals is the need for a "disproportionate share" adjustment for hospitals treating a large number of low-income patients. The purpose of such an adjustment is to recognize the fact that hospitals caring for a disproprotionately large number of low-income patients tend to have a Medicare cost-per-case higher than the national average. The reasons for this relationship remain unclear, but may be related to differences in the average severity of illness experienced by Medicare patients treated in those hospitals, the systematic bias against high-cost DRGs created by the current method of setting prices, or the problems that have been experienced with the area wage adjustment. Whatever the reasons, the effect of moving to uniform rates is to penalize these hospitals, further adding to the financial stress associated with a substantial volume of uncompensated care.

Mr. Chairman, as I indicated to you on April 15, at a hearing on Medicare budget issues, the AHA is committed to working with this Subcommittee in identifying hospitals that may qualify for a "disproportionate share" ajustment. On April 12, I wrote to 1,248 hospitals, asking their administrators to sign release forms regarding revenue data reported to the 1983 Annual Hospital Survey. Most of those hospitals already have cooperated in submitting the forms, and others are sending them in, in a daily flow. Moreover, other hospitals—those not on my original mailing list—have indicated that they would release their revenue information as well. On behalf of the AHA, I reiterate my pledge to work with you in addressing the adjustment.

CONCLUSION

Medicare, in fact all of health care, is at a critical turning point. With adopton of prospective pricing for Medicare and developments of initiatives in the private health sector, incentive-based approaches are demonstrating that they are effective in containing health costs. At the same time, Congress, HHS, and the industry must cooperate in assuring that the approaches work efficiently and fairly. The time taken for such assurance need not be accompanied by high increases in health costs. During the past year, under a system largely based on hospital-specific prices, the hospital industry achieved the lowest rate of increase in costs since 1963, the year in which the AHA began its routine survey of expenses and utilization.

The development of a workable, equitable prospective pricing system is made more difficult by the need to deal with the federal budget deficit. The AHA recognizes that hospitals will have to contribute their share to the solution of the deficit problem. However, hospitals, and the Medicare beneficiaries they serve, should not be required to bear more than their fair share of the deficit reduction effort. In addressing that effort, as well as the issues discussed above, the AHA takes the following approach:

Any reduction in payment should be the result of congresional action, rather than of regulatory fiat.

A freeze should be only for one year, followed by an increase of the hospital marketbasket plus one-quarter of a percentage point, as now provided for in law. Such a freeze would create hardships for some hospitals. It must be clear that, if the present system of payment for hospitals which is working, is going to provide adequate care for beneficiaries, a freeze cannot be maintained for more than one year.

Correction of the area wage index should take place before the freeze becomes effective. Imposition of a freeze without correction of the index would mean the carrying forward of index inequities for another year, with intensification of their penalties.

Because a freeze on payment will exacerbate the anticipated problems of hospitals offering needed, but costly, referral services and treating the most complex mix of Medicare cases, hospitals should be given an assurance that they will be paid no less in FY 1986 than they were in FY 1985.

Due to significant problems with the current system of DRGs and price-setting, immediate attention should be given to the development of an alternative to the planned transition to uniform rates. Uniformity is not necessary to realize the benefits of prospective pricing, as has been demonstrated by the past year's performance. The AHA believes that DRG-specific price blending offers the best method of achieving equity, while preserving the positive incentives of prospective pricing. Not only should this proposal be adopted, but also work should proceed on several other issues, including the recalibration of DRG cost weights to reflect more acurately the relative cost of treating patients in each DRG and the development of more accurate labor market definitions.

The problems of hospitals treating a disproportionate number of low income patients should be addressed through the creation of an adjustment to the DRG price schedule. This adjustment could be implemented with minimal impact on the overall federal budget deficit, and would protect hospitals that critically are needed by their communities.

The AHA appreciates this opportunity to present its views on Medicare prospective pricing issues, and offers its assistance to the Subcommittee in bringing greater equity to the prospective pricing system.

Chairman STARK. Thank you very much. I appreciate the spirit in which you have presented your testimony. We have your complete testimony for the record.

Mr. OWEN. Thank you.

Chairman STARK. You have been very helpful. All hospitals must take assignments, is that not correct?

Mr. OWEN. That is correct.

Chairman STARK. What sort of havoc would it wreak on the system if we required all physicians to attain assignments? It hasn't bothered the hospitals, has it?

Mr. OWEN. Hospitals are different. The real question down the road is if you keep cutting back on the price and move to a national price, then the question is going to be, if that price is less than the fixed cost of an institution, can an institution exist with that lower price? Then the question is, should it go to the patient for the additional dollars?

To comment on whether the physicians can live with assignment or not is really one you should ask the American Medical Association because I think it would give you a better answer than I could give you.

Chairman STARK. I think it might be a different answer, not necessarily better. I just thought you might like to comment.

If we agree to the freeze on this transition issue, which you seem to reluctantly say you could live with, do you really think we will then be giving up getting to national DRG rates?

Mr. OWEN. No, I don't, Mr. Chairman. For the past 2 years, we have been advocating moving to a national rate with a coefficient of variation, which is a blend that takes into account some of the oddities that occur in different parts of the country. But moving to a single national rate that does not take any of these into account is not going to do the hospital field any good in the long run.

Chairman Stark. Is it your opinion that it would be impossible in calendar year 1985 to arrive at a—allow the transition to go forward, take us to 75 percent, and arrive at a change or the adjustments that you feel would be necessary in a national adjusted DRG rate? Would that not be better?

In other words, it seems we have two choices—three. We can freeze at 50-50. Let's assume for a minute—one would presume, although with the cooperation we get from HCFA that is a wild assumption, we could then gather enough information in the year of the freeze to figure out where we ought to go. We can let it go to 75-25 and also attempt to make the necessary adjustments legislatively that would, that I think you are suggesting need to be made; or we can roll up our sleeves and say "Let's get it done this year."

If we make any change, let's make the changes toward the national system with the adjustments you feel necessary. Can we do all three of those or, in your opinion, is there not enough time to do a decent job?

Mr. Owen. Well, I think time is not of the essence as far as moving toward a blended national rate. We think that can be done rather quickly. The mechanics are there, it has been tested, and we know it will work. The problem is what happens with Congress on the budget deficit and a freeze. If there is not going to be a freeze on hospital increases or rates—and that is what I would advocate, of course, you understand that—then I would say let's move ahead and correct what needs to be corrected.

Chairman Stark. We are between five-one-five and zero.

Mr. Owen. That is right.

Chairman Stark. What is the absolute minimum, in your opinion, to the nearest percent, that you would have to have in an increase to allow us also to take care of the transition problem?

Mr. Owen. I don't think you could go less than four.

Chairman Stark. We don't have that much money. Try again.

Mr. Owen. What I was really thinking about is 5.6.

Chairman Stark. You know, that is—you know.

Mr. Owen. I think in order to do what needs to be done, it is policy. It is not budget dollars. That is what we are working with. Right now we are working with a very limited amount of budget dollars. You are faced with a very serious problem of do you freeze rates? Our position is, if you have to go that route, then let's take that year with everything frozen and let's correct the national rate with a coefficient of variation, let's get rid of the inequities, let's talk about the indirect education factor.

Chairman Stark. Could we do this? Using the pressure this feeling about the transition gives us, helps pass the legislation. It keeps attendance high at hearings and does a lot of good things when you are trying to pass legislation. Would it be possible, assuming for the moment we have a freeze? I really don't think we will have a complete freeze.

Mr. Owen. Glad to hear that.

Chairman Stark. But let's assume packaged into the transition question, could we do it all at once and say, "All right, we will have the freeze." We will stay at 50 percent for a year, but rather than a freeze, we will just change the transition to a blended DRG rate. Could we get that done with your assistance? We aren't going to get any information out of HCFA. So we might as well get it from you.

Mr. **Owen**. I think we can get it done. I don't want to speak for the other witnesses who are going to appear today, but I think, when you talk to the Illinois people and California people and even those from Alabama and the South, most would agree that a national blended rate is better than sticking at either the 50-50 or moving it ahead.

Chairman **Stark**. Would you agree a plain, simple old 50-50 freeze would be less desirable than a 50-50 freeze and resolving the problem of what we are going to get the year after?

Mr. **Owen**. I would agree with you, that if we could avoid the 50-50 conflict that exists and move toward a blended rate, we wouldn't have to worry about the 50-50 or 75-25. You would be talking about a national rate with a blending factor. That is what is needed. That gets rid of the urban-rural problem, indirect and all the other inequities we have.

Chairman **Stark**. Your blended rate includes a little hospital historic rate in it.

Mr. **Owen**. Yes.

Chairman **Stark**. About how much? Where would we be in the transition as near as you can estimate?

Mr. **Owen**. What happens in a blended rate is that there are probably about 15 percent of the DRG's which would be a national rate, for which everybody would get the same price. Say, a simple appendectomy. It doesn't matter where you go, to a university hospital facility, or rural or what, the price is that.

Chairman **Stark**. I can't believe California isn't higher.

Mr. **Owen**. But you may not want to pay——

Chairman **Stark**. Even the doctors there, you know.

Mr. **Owen**. But the issue is not whether it is more, but what the government puts onto the price. The other side of this is about 15 percent that involve very highly technical kinds of cases, such as neurosurgery in which a lot of it is hospital-specific. Then in between there is a variation where some hospitals would have national rate, some would have a more hospital-specific, based on what is current.

Let me make sure the committee understands one thing: When we talk about hospital-specific, we are not talking about going back to a cost reimbursement system. Hospital-specific is only a proxy. The Government is still setting the price. The price is set by the Government.

Now, whether it is based on a hospital-specific proxy or based on a national proxy, HCFA is still putting a price on it. If that were not the case, we wouldn't have seen the change that took place in the first year, because we had a 75 percent hospital-specific proxy with only a 25 percent regional. Yet we saw dramatic change take place in the first year.

So the change took place because of the prospective pricing system, not because of the proxy that was established, whether it was hospital-specific or national rate, because as long as the Government is setting the price, it doesn't matter what proxy you use.

If you are going to freeze the price, you are going to move forward. The Government is setting the dollars the hospital gets.

The only question now is, how do you make it more equitable? What wage index, for a specific kind of problem the Midwest is facing. It wasn't equitable out there.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Thank you very much, Mr. Chairman, for the pursuit of that questioning. I appreciate, Jack, your clarifying what happens when you start talking about blended rates. We don't want to go backwards, we want to go forward. Thank you for your concept of going toward a more accurate, wage index formula. This is something I think was inherent in the promise of what we would do to the system.

I look forward to working with you to accomplish that. Do you have a preference as to whether we go the adjusted gross or gross wage index?

Mr. **Owen**. I think gross is probably the better way to go, though there are pros and cons on both of them.

Mr. **Daub**. Did you hear my thought about how to update it thereafter?

Mr. **Owen**. I think there are probably a couple ways to update it. I don't know if you need to update yearly, but the data provided to HHS this year came from the hospitals. There is no reason the hospitals can't do it on an every-2-year basis or every year, for that matter. But I think whether you need to do it every year remains to be seen. I would guess it would not be a problem, at least every 2 years.

Mr. **Daub**. We sure thank you for the testimony and the opportunity to examine your members' data base. I am going to be interested in pursuing that. We appreciate it very much.

Mr. **Owen**. There may be some other hospitals that haven't given us their information yet. We will get that to you too.

Mr. **Daub**. Mr. Chairman, I yield the balance of my time.

Mr. **Gradison**. Mr. Owen, with regard to the list you gave us, first I would like to indicate how pleased we are to have it. I am sure it will be extremely helpful. I would like to ask a little background about how it was prepared so we can judge its comprehensiveness.

Mr. **Owen**. OK. All right.

Mr. **Gradison**. What was the process used in putting it together?

Mr. **Owen**. What we do, we have a statistical arrangement with all the hospitals in the country, some 6,100 of them, in which we obtain revenue and cost and information on just about all of the statistics they have. Then we collect those data and put it on our computer so we can look at problems that are coming up in regard to prices and whatever happens to come along.

This, in this particular case, we were concerned about doing something to help disproportionate share hospitals. We felt one way to approach this was to look at those hospitals that had a higher-than-average number of Medicaid and charity and bad debt cases. So we asked that the hospitals, when they reported, to identify the percentage of Medicaid and charity to their total revenue. We then looked at the list and came up with 13.7 as the average. That was a little higher than Mr. Dobson was talking about—he was talking about 11—but he didn't have charity in there. Charity is equally important.

There are about 1,248 hospitals that fall above 13.7 percent. CBO said 20 percent was a better figure to go with. That cutoff reduces the number to about 658. So we looked at the 20 percent, and those are the two lists that you have there. One is the 20 percent, one is the 13.7.

Mr. GRADISON. How comprehensive are the lists? Do they include the whole thousand?

Mr. OWEN. No, they don't. Those are the ones for which we have already received OK's from the hospitals to make their information public. The other list, if you go into executive session, we can talk about the complete universe. In the meantime, we are continuing to get letters from the hospitals OK'ing us providing this publicity. So we will continue to add hospitals to the list. But if you need to use it faster than that, we can probably do it, as the chairman suggested, in executive session.

Mr. GRADISON. Approximately how many institutions are covered?

Mr. OWEN. About 658 hospitals in the 20 percent. There are about 1,248 in the 13 percent.

Mr. GRADISON. In the list you gave us?

Mr. OWEN. No. In the list I gave you, there are about 700 in one and over 300 in the other. But the 1,248 and 658 are total universe.

Mr. GRADISON. The total universe. So we have figures then on about 60 percent of those, did you say 12, 13.7?

Mr. OWEN. 13.7.

Mr. GRADISON. About 60 percent of that universe?

Mr. OWEN. That is correct. We have the total universe available; we just can't make it public until we get the approval unless you go into executive session.

Mr. GRADISON. So the fact an individual institution is not listed does not necessarily mean they are not disproportionate share hospitals?

Mr. OWEN. That is correct. We would have to check with our master list to see.

Mr. GRADISON. Mr. Owen, we get more and more data which suggests hospitals are doing pretty well financially right now. The most recent I have seen was the article that appeared I think a week or so ago in the AMA News. They indicated, just reading the lead of the article, "Despite declining admissions and plunging occupancy rates, the hospital industry in 1984 showed its healthiest bottom line in more than 20 years, according to the AHA."

Do you have these data broken down on a regional or State basis, or some way we might have to relate to some of the things that we are being told here about the plight of institutions in some areas versus others?

Mr. OWEN. No. We do that with a panel. We have 2,000 hospitals in a panel as representative of the 6,000. It comes within a few fractions of a percentage point of being accurate when we do a universal study. So we feel that is what is happening. The 2,000 represents the 6,000, but I don't have it broken down by State.

Mr. GRADISON. Could you break it down from the panel of 2,000?

Mr. **Owen**. Well, you might get a crude picture if you break it down by State, because we might not have enough in a particular State, if you are looking, for instance, to areas of the Northeast or Midwest or something like that, we would have to check to see that that panel really represented that State.

I would be hesitant about doing that without taking a closer look to see whether it really did represent that State.

Mr. **Gradison**. Could you take a look at it, and if you feel it is not unrepresentative of the total universe, would you consider sharing that with us?

Mr. **Owen**. Yes.

[The following was subsequently received:]

HOSPITAL MARGIN PERFORMANCE: 1983-84, MAY 30, 1985

Introduction: The hospital economic environment has undergone significant changes in recent years. Medicare, Medicaid, and private sector health financing programs are evolving towards greater use of positive price incentives for providers and consumers. In general, these changes should produce public benefits from increased economic competition in health care. However, to the extent the changes involve untested programs or are budget-driven, they pose risk to the accessibility and quality of health care. To be managed, the risk must be monitored, and hospital financial health is a critical "early-warning" indicator. One important measure of hospital financial health is margin—the percent of revenue retained after expenses. Between 1983 and 1984, hospital margins in aggregate increased.[1] However, from this simple observation, it does not follow that policy issues concerning hospital payment can be taken lightly. It is important to consider both 1) the sources of margin increases and 2) the uneven nature of margin experience across hospitals. Both points are discussed below.

Anatomy of the Margin Increase: Hospital expense and revenue trends for 1983 and 1984 are the principal components of the margin trends. Cost containment pressures and incentives along with hospital responses to them led to a dramatic slowdow in hospitals costs. Total expenses including inpatient and outpatient services slowed from 10.2 percent in 1983 to 4.6 percent in 1984, as measured by the American Hospital Association's National Panel Survey of Community Hospitals.

There was also a sharp slowdown in the growth of patient revenue between 1983 and 1984, from 10.5 to 5.6 percent. On the inpatient side, revenue growth slowed from 9.8 to 4.3 percent. Growth of outpatient revenue (from emergency rooms, hospital-associated clinics, and hospital ancillary departments), in contrast, slowed only from 14.6 to 13.7 percent between 1983 and 1984. These relative inpatient/outpatient revenue trends are consistent with the increasing use of outpatient alternatives to inpatient care.

Because the slowdown in expense growth was steeper than the slowdown in revenue growth, overall patient margin increased from 1.0 percent in 1983 to 2.0 percent in 1984. This continued a longer-term trend. Adding in revenue from non-patient care sources (gifts, investment income, and cafeterias for example), aggregate margins increased from 5.1 percent in 1983 to 6.2 percent in 1984. Thus, while non-patient income comprises the larger part of margin, patient revenue has accounted for most of the aggregate margin increase.

Performance Variation: Aggregate margin figures—combining data from many hospitals—are, at best, crude indicators of hospital financial health, much as the Gross National Product is only a crude indicator of the underlying health of the nation's economy. On a hospital-to-hospital basis, there is substantial variation in expense, revenue, and margin trends. This variation is suggested by the attached table on margin aggregates at the regional and bed-size category levels (Table 1). Not all categories registered the same margin increases between 1983 and 1984; some even showed decreases.

There is also substantial margin and trend variation within regional and bed-size categories. While the National Hospital Panel Survey was not designed to produce valid estimates for aggregates below the regional or bed-size group level, the data can be used to get a sense of the degree of margin performance variations at the individual hospital level. This was done in the following way.

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[1] As measured by the AHA's National Hospital Panel Survey.

First, to remove the seasonal effects of expense and revenue data, the analysis was restricted to hospitals which reported date for each month over a twelve month time period. Second, to measure change, the analysis was further restricted to the 292 hospitals which reported for each month of 1983 and 1984.[2] Third, the data were adjusted to match the bed-size distribution of community hospitals generally. Finally, the 292 hospitals were classified into 6 patient and 6 total margin categories in both 1983 and 1984. The results are shown in Table 2.

Several key results emerged from the analysis. First, whether looking at patient or total revenue margins, substantial numbers of hospitals were outside the categories which contained the respective national margin figure. For example, for both 1983 and 1984, less than 26 percent of the 292 hospitals were in the 0.0 to 2.9 percent patient margin category. This is the category that "represents" the national average margins of 1 percent in 1983 and 2 percent in 1984.

Second, not all hospitals experienced positive margins in 1984. Of the 292 hospitals, 22 percent had negative 1984 total revenue margins, and 45 percent had negative patient margins.

Third, not all hospitals experienced increasing margins. Between 1983 and 1984, 33 percent of the hospitals fell to a lower margin category (half of these fell from positive to negative margins) and 31 percent fell to a lower total margin category. About 12 percent fell from positive to negative total margins. All regions and bedsize groups were represented in the "decline" category. The patient and total margin distributions may be somewhat different for the universe of 5,800 community hospitals, however, the fundamental point of the above analysis on 292 hospitals will still hold true. Along with the economic success of some hospitals, it is evident, that economic problems remain for a large percentage of community hospitals—problems that are marked by looking at group averages. Simple averages submerge the economic problems of hospitals disadvantaged by design flaws in the Medicare PPS system, in other public and private payment systems or associated with substantial commitments to serving uninsured and underinsured patients.

Due to data limitations, it is not possible to identify, quantitatively, how much of the margin increases or decreases are created by inpatient versus outpatient services, payment system design problems, or other factors. This holds true for the regional and bedsize margin data as well. To collect timely monthly information from over 1,500 hospitals, the items on the Panel Survey are necessarily limited to key performance measures.

IMPLICATIONS

It should be noted that the 1984 margin figures reflect a period when hospitals were by and large operating under a Medicare TEFRA rate of increase target and/or a blend of 75% institution-specific and 25% regional PPS rates. Accordingly, one can anticipate that difference in margins both within and across regions and bed size categories will become much more pronounced in 1985 under a 50/50 blend of institution-specific and federal rates, and would become extremely pronounced if the transition moves to the next phase of 25/75.

Our major concern is that because of the generally acknowledged inability of the current DRG system to account adequately for severity of illness and other patient differences across hospitals within DRGs, a rapid movement to national rates will result in significant portions of hospitals experiencing substantial financial losses under Medicare that are unrelated to efficiency. For that reason, the AHA has advocated replacing the current transition system with a mechanism that blends institution-specific and national average rates (without an urban/rural distinction) on a DRG-specific basis, with the blend percentages for a DRG in a given year based on the most current available data on how widely and narrowly patient costs per case are distributed around the national average cost for that DRG. A fairly narrow distribution for a DRG indicates that it does a good job of grouping together patients with similar resource requirements. A wide distribution for a DRG indicates that it requires considerable refinement before basing much of its price on a national average rate.

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[2] In a given month, an average of 988 hospitals out of 1,600 (or 62%) provide date to compute margins.

TABLE 1.—COMMUNITY HOSPITAL REVENUES MARGINS, 1983 AND 1984

Region	Total net margin		Percentage point change	Net patient margin	
	1983	1984		1983	1984
New England	2.9	4.4	1.5	−1.2	0.2
Mid-Atlantic	.7	2.0	1.3	−4.0	−2.6
South Atlantic	6.3	7.9	1.6	1.5	3.0
East North Central	5.0	6.3	1.3	1.0	2.4
East South Central	7.0	7.1	.1	1.9	2.2
West North Central	4.7	6.4	1.7	.4	1.7
West South Central	8.6	7.7	−0.9	4.8	3.6
Mountain	7.0	4.7	−2.3	3.7	1.0
Pacific	7.0	8.8	1.8	3.5	5.5
U.S. total	5.1	6.2	1.1	1.0	2.0
Bedsize:					
Less than 25	3.9	−8.9	−12.8	−1.4	−14.2
25 to 49	7.2	4.3	−2.9	4.4	1.4
50 to 99	5.7	6.3	.6	2.1	2.7
100 to 199	6.1	7.2	1.1	2.9	3.8
200 to 299	5.5	6.8	1.3	1.7	2.7
300 to 399	4.8	6.4	1.6	1.2	2.9
400 to 499	4.9	5.0	.1	.2	.3
500 or more	4.3	5.7	1.4	−1.1	.5

Source: National Hospital Panel Survey, American Hospital Association, Chicago, IL. Copyright 1984.

TABLE 2.—REVENUE MARGIN DISTRIBUTIONS

	Net patient margin				Total net margin			
	1983		1984		1983		1984	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
−6.0 percent and below	35	11.9	51	17.6	12	4.0	25	8.6
−5.9 to −3.0 percent	27	9.2	39	13.2	11	3.6	15	5.0
−2.9 to −0.1 percent	60	20.5	41	14.0	27	9.3	23	8.0
0 to 2.9 percent	75	25.6	60	20.5	74	25.3	50	17.2
3.0 to 5.9 percent	53	18.0	52	17.7	67	23.1	69	23.6
6.0 percent and above	43	14.7	50	17.0	101	34.6	110	37.6
Total	292	100.0	292	100.0	292	100.0	292	100.0

Source: Special Analysis, Office of Public Policy Analysis, American Hospital Association, Chicago, IL. Copyright 1985.

Mr. **Gradison**. I don't think we are so much interested in individual institutions as seeing how States and regions stack up. I think States would be more helpful in light of the testimony we have been receiving so far this morning and are likely to get in the afternoon.

Mr. **Owen**. If we don't have to give hospital names——

Mr. **Gradison**. We don't need that. The assertion is being made, and may be entirely correct, that in certain States institutions are very hard hit and would suffer grievously if we don't slow down this transition. You appear to have the best possible source of data to help us test that assertion.

Mr. **Owen**. One thing I would caution is that that report that appeared in the AMA newsletter is all patients, not just Medicare. A hospital may have done fairly well because of its relationships with industry or something else in a particular community and lost money actually on Medicare. We have to be careful when we are looking at the total revenues of a hospital, not saying that that is the end result of the Medicare Program. We have to be careful and not draw conclusions that Medicare has provided this revenue over expense solely.

Mr. **Gradison**. No, I understand that. I am trying to see what data we might be able to obtain that would help us test the assertion that an allegedly inadequate payment from Medicare would force these institutions to the wall and put them out of business. If they have sufficient earnings from non-Medicare business to offset the alleged underpayments from Medicare, presumably they wouldn't be pushed to the wall, so examining their overall financial conditions, it is not unreasonable.

I am not suggesting that Medicare should consciously underpay to take advantage of profits on non-Medicare business. That isn't the point. I think it is just a quick measurement of the financial health of this essential element of the provider industry to see just what is happening overall, not as a result only of what Medicare is doing, but what others are doing as well.

Mr. **Owen**. We do know there are regions where moving toward a national rate will have more effect than other regions as you move toward the national rate. That, we know. That, we can make available to you.

Mr. **Gradison**. That would be very helpful if you could share that.

[The information follows:]

PERCENTAGE OF HOSPITALS POTENTIALLY EXPERIENCING A LOSS IN THE THIRD YEAR OF PROSPECTIVE PRICING [1]

Case mix index quartiles	U.S. total [2]	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mount	Pacific
0.5021 to 0.9368	66	65	71	55	68	66	73	66	61	65
0.9369 to 0.9962	75	76	76	71	81	66	74	75	77	74
0.9963 to 1.0609	83	88	84	79	85	94	82	78	87	80
1.0610 to 1.6495	78	92	90	87	90	92	86	91	88	78
Overall	78	86	85	73	83	74	77	72	77	77

[1] Assumes rates are forzen and indirect medical education is halved. Does not include payment for capital or direct medical education.

[2] Waiver States included throughout table.

Analysis of the impact of prospective pricing when the blend transition is allowed to continue to 25 percent hospital specific and 75 percent Federal rate shows that potential losses do vary across regions. (This analysis assumes the rates are frozen, the indirect medical education factor is halved, and hospital costs increase at the rate of the market basket plus one percent.) The percentage of hospitals that potentially experience a loss ranges from 72 percent in the West South Central Region to 86 percent in New England. Within regions, there is generally the same pattern described in my prepared remarks: the higher the case mix index of hospitals, the greater the percentage of hospitals experiencing a loss.

Mr. **Gradison**. Mr. Gregg.

Mr. **Gregg**. Thank you.

Can you tell us a litle bit about your views on the elimination of the return on equity?

Mr. **Owen**. I would be happy to. The return on equity issue in my estimation is primarily a capital issue and should be contained in the context of the whole capital situation. We are in a situation right now where we are moving into a pricing system, or we moved into a pricing system at the same time capital was left out of that pricing system. And while it is out of that pricing system, it is really not in effect a complete pricing program because when you buy something, for example, a cup, if it is a dollar you don't say here are 90 cents and 10 cents for your capital.

You say here is a dollar, and you don't care how that industry makes its cup, whether by hand or by machine. Our position has been that the capital issue must be tackled and that the return on equity becomes moot when the full capital issue is comletely worked out. And the reason it becomes moot is that there is a price for each DRG.

In that price you earn a return on capital and earn a return of capital. It is the same for everybody who is operating, competing for that price. At the present time, it is just stuck over on the side. It is like indirect medical education. All these things should be left alone until such time as a pricing system is devised which includes indirect medical education, medical education, and capital.

Otherwise you are just picking away at pieces and probably going to do more to harm the prospective payment system than anything that can be done by tackling, cutting in half indirect medical education, by freezing back to 1983 rates on direct medical education, by talking about return on equity.

All of these things need not be looked at on the basis of a pricing system.

Mr. **Gregg**. We know in the indirect medical education that the 11 pecent is a little high.

Mr. **Owen**. Well, we know that the indirect medical education, when it was taken as a proxy, looked like it might be too high. But I am not prepared to say it is too high at this time because it was there as a proxy which was suppose to take care of a number of things; one being intensity of services. And there was a lot more costs in a teaching facility.

Most of the big, large teaching hospitals only came into the program July 1, 1984, so that they have not even completed a full year in the program. Yet, we are saying the indirect factor is too high. I don't see any evidence at this point that it is too high or too low. I think it was an arbitrary decision, we could probably argue that maybe it should have been 9 percent or something like that. But again, to go back to setting proper prices using a blended rate, that would have been taken care of.

Otherwise, it is always to pick and choose when one committee thinks it is too high, another thinks it is too low—you go back and forth.

Mr. **Gregg**. How far away are we from being able to set a DRG rate which would adequately reflect capital?

Mr. **Owen**. I don't know. You heard the reports that are coming out. We have a position that says that you ought to move ahead. The problem is the transition period, and to make it fair there ought to be a 15-year transition period. During those 15 years hospitals move into a capital with a price, and by the end of the time the hospitals in the low part of the cycle have completed their way of getting back to the level playing field, it will be all part of the price. It could happen soon.

Mr. **Gregg**. Now, ProPAC has told us they are recommending a market basket minus one. You said you want market basket plus a quarter. Can you live with market basket minus one?

Mr. **Owen**. Yes, a lot better than we could a freeze. The reason I said market basket plus a quarter, because that is the law. I mean the law as far as it exists right now. ProPAC, which is supposed to give advice on what that should be, came out with market basket less one. We could probably argue with that, but it is certainly a fairer approach than a freeze is.

Mr. **Gregg**. Is that a fair approach if we combine it with an adjustment to the DRG payment rate which would reflect hospital costs which weren't appropriately taken into account originally?

Mr. **Owen**. I am not sure I am familiar with what report you are talking about.

Mr. **Gregg**. I am referring to the hospital costs used to establish the DRG rates which according to GAO were not appropriately audited, thereby causing DRG rates to be overstated by about $800 million

Mr. **Owen**. I haven't seen those figures and can't really debate them. But I think you have to keep in mind that the DRG system was a brand new approach. It was an approach in which we were kind of going by the seat of our pants, both the Government and hospitals, that we wanted to get off the old cost reimbursement system. We all recognized it wasn't a good one, and that there had to be some way to start setting the price.

The price was established based on some 1981 data, I guess we would all agree was not accurate. Some was below what it should have been. Some was higher, but it was a price and it was an effective price because what it did was lower the amount of money coming out of the trust fund and extended the length of the trust fund by that price. What we are saying is that sure there are corrections which need to be taken in the price. There needs to be recalibration, but don't do it if you are going to freeze. Do it on the basis of all the rest which proceed too, which means market basket plus a quarter.

If you can't go along with market basket plus a quarter, how can you go along with just changing the bottom side? That is going to create some problems that our hospitals will have difficulty with if that continues.

Mr. **Gregg**. Thank you.

Chairman **Stark**. Jack, thank you. I apologize for the sporadic sort of shifting of chairs here. Can I just review a couple questions? I want to make sure just for the record that they were asked at some point. Did Mr. Daub ask you which of the two wage index options you preferred.

Mr. **Owen**. Yes, I think, yes, Mr. Daub did. That's right. We said the gross——

Chairman **Stark**. Were you asked about indirect medical education?

Mr. **Owen**. Yes.

Chairman **Stark**. OK.

Mr. **Owen**. We don't think it should be cut.

Chairman **Stark**. Were you asked why Medicare should continue to pay a return on equity capital payments?

Mr. **Owen**. Yes, I was asked that, too.

Chairman **Stark**. All right. Things get done in my absence. Thank you very much. I appreciate your patience and help and we will look forward to working your statistics and I hope we can move ahead. I appreciate that very very much.

Mr. **Owen**. Thank you, Mr. Chairman.

Chairman **Stark**. Unfortunately, Ms. Clarice Jones, chairperson of the American Association of Retired Persons, had to leave for the airport. Is there anybody else here representing AARP who wishes to testify? If not, Ms. Jones' statement will appear in the record in its entirety.

We apologize to the American Association of Retired Persons for our scheduling. The next witness, it says, will comprise of a panel of James Bentley, associate director of the Department of Teaching Hospitals, American Association of Medical Colleges. Dr. James Mongan, executive director of the Truman Medical Center, Kansas City, with the National Association of Public Hospitals and Mike Bromberg, executive director of the Federation of American Hospitals.

Gentlemen, welcome to the committee. I will ask you to proceed in the order which you appear on the witness list unless you desire otherwise. Dr. Bentley, proceed.

STATEMENT OF JAMES D. BENTLEY, PH.D., ASSOCIATE DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. **Bentley**. Thank you, Mr. Chairman. For the past 7 years, I have spent the majority of my professional life working on the prospective payment system. In doing that, I have served both as an external adviser to HCFA and provided technical guidance and assistance to teaching hospitals. In light of the comments this morning, I would like to concentrate my discussion on both the price per case issue and resident to bed adjustment.

To appreciate the dynamics of the Medicare prospective payment system, it is crucial to recognize that the basic unit of payment is the individual patient. The actual payment for a patient is determined by adjusting an average price by an index of expected case costliness or the DRG weight. I wish to concentrate on that average price which we have been discussing extensively this morning.

During the transition period hospitals began with a base of 75 percent of their own cost. By the fourth year they receive a price per case based upon 100 percent on the national average. It is adjusted by an area wage index to recognize differences in the cost of employees' salaries.

It must be understood that by year 4, only two differences across hospitals are recognized in the basic DRG payment, area salaries, as measured by the wage index, and type of patient as measured by the DRG category. All other differences are ignored by year four. The differences ignored include hospital bed size, range of services offered, socioeconomic mix of patients, central city or suburban location, and input price differentials other than wages.

Past research has shown each of these variables account for real differences in hospital costs. Ignoring these variables has caused relatively minor problems to date because at this point most hospitals have been paid either 75 or 50 percent on a hospital specific component. That component reflected historical cost by which that hospital differed from the average.

As we move forward in the transition, however, the hospital specific price component decreases and the price paid does not recognize major differences in the cost of different hospitals. This lack of adequate adjustments could be substantially ameliorated if the line of discussion that was carried on with Mr. Owen would proceed with either of these options: one, either by retaining a significant portion of the hospital-specific; costs; or, two, by revising the perspective payment system to incorporate the coefficient of variation approach which the Association of Medical Colleges supports; or three, by including a number of other variables which—by which hospital costs systematically vary.

If we are not willing to make that kind of improvement in the scheme, the AAMC would recommend we put the transition schedule on a temporary hold so payments are based 50 percent on hospital costs and 50 percent on regional average costs. We believe the 50 percent regional component provides hospitals with a strong incentive to increase their efficiency, and the 50 percent hospital-specific component provides Congress with an opportunity to identify and correct weaknesses in the system before substantial damage is done to hospitals and thier communities of patients.

Finally, I wish to note and turn my attention to the resident-to-bed adjustment, the so-called indirect medical education adjustment. It is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Thus it helps correct for the fact that too few variables, as I have been discussing, are used to set prices in the current system. Nevertheless its medical education label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in costs between teaching and nonteaching hospitals.

This misperception or possibility of misperception has caused us great concern. The resident per bed adjustment, we believe, is a crucial equity factor under prospective payment. We believe it should be retained, but as we testified last month, we believe it should be properly estimated. An unbiased and more defensible adjustment can be obtained if the adjustment is reestimated with an equation based only on those factors used in determining the DRG payments and as soon as possible, with up to date and accurate data.

We would encourage this subcommittee to retain the resident-to-bed adjustment and to encourage the administration to reestimate that adjustment both in terms of the equation itself and when available in terms of more up to date and accurate data. Thank you.

Chairman Stark. Thank you very much.

[The prepared statement follows:]

STATEMENT OF JAMES D. BENTLEY, PH.D., ASSOCIATE DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on technical issues underlying the current policy debate for Medicare's prospective payment system. The Association's Council of Teaching Hospital's (COTH) includes over 350 major teaching hospitals participating in the Medicare program. In 1982, the most recent year on which the Association has data, COTH hospitals cared for over 1,680,000 Medicare admissions. Thus, the Medicare prospective payment system has a major impact on our members.

I am James D. Bentley, Ph.D., Associate Director of the Department of Teaching Hospitals at the AAMC. I have been involved with the technical and policy issues surrounding prospective payment since the late 1970's:

- in 1980, I coauthored Describing and Paying Hospitals: Developments in Patient Case Mix;

- in 1981 and 1982, I directed technical reports on the ability of the DRG and disease staging methodologies to account for differences in the costs of 24 teaching hospitals;

- in 1982, I served as an External Advisor to the HCFA Administrator's Prospective Payment Task Force; and

- since January, 1984, I have served as a member of HCFA's Technical Advisory Panel on Prospective Payment Studies.

Thus, I have had considerable personal experience in the technical details which underlie the prospective payment system, and this experience has been from the perspectives of both the system designer and the hospital expected to live under it. This morning, I would like to address six of those technical concerns:

- the factors used by prospective payment to account for differences in hospital costs;
- the relationship between prospective payment prices and the phase-in schedule;
- the computation and role of the resident-to-bed adjustment in a system which uses hospital-weighted prices but lacks a measure of patient severity;
- the method for determining Medicare's share of direct medical education expenses;
- a suggestion for assisting disproportional share providers; and
- the legislated retroactivity of the wage index adjustment.

Prospective Payment: Explaining Hospital Differences

Under prospective payments, hospitals receive up to six different types of payments for inpatient services:

- Cost Reimbursement Payments
  - Direct Medical Education Costs
  - Capital Costs (through 1986)
  - Distinct Part Units
- Prospectively Determined Payments
  - Per Discharge DRG Payments
  - Outlier Payments
  - Resident-to-Bed Adjustment Payments (in teaching hospitals)

Because the capital and direct medical education payments are made on a cost reimbursement basis, these costs are currently recognized and paid in full. Similarly, unless a hospital's costs in exempt-part units exceeds its own inflation-adjusted base year costs, costs of exempt-part units are recognized and paid in full. Thus, I will return to only one of the payments, the direct medical education passthrough, late in my testimony.

For the prospectively-determined payments, it is crucial to recognize that the basic unit of payment is the individual patient. The actual payment is determined by adjusting an average price by an index of expected case costliness (i.e., the DRG weight). At this point, I wish to focus my comments on the determination of the average price.

The average price for a hospital is based on its own hospital-specific costs, the average costs of hospitals in its region, and the average costs of hospitals nationally. During the transition period, hospitals began with a price per case based 75% on their own costs. By the fourth year, hospitals received a price per case based 100% on the national average. The national average for a particular hospital is adjusted by an area wage index to recognize differences in the cost of employee salaries.

It must be understood that by year four only two differences across hospitals are recognized in the per case payments: local area salaries as measured by the wage index and the type of patient as measured by the DRG categories. All other differences in hospital costs are ignored by year four. The differences ignored in prospective payment include hospital bed size, range of services offered, socioeconomic mix of patients, central city or suburban location, and input price differences other than wages. Past research has shown each of these variables account for real differences in hospital costs. Ignoring these variables caused relatively minor problems when prices were based 75% on the hospital-specific price component because the hospital's historical costs reflected all of its differences from the "average" hospital. As we move forward in the transition, however, the hospital-specific price component decreases and the price paid does not recognize major differences in the costs of different hospitals.

Therefore, the AAMC believes a key cause of the technical and policy problem confronting this Subcommittee is the use of too few variables in setting the price per case for hospitals. As the hospital-specific price component disappears, the present system lacks adequate adjustments that would recognize legitimate differences in the costs of different hospitals. This lack of adequate adjustments could be substantially ameliorated if the price per case retained a significant component of the hospital-specific costs. Therefore, the Association recommends either:

- o AMENDING THE PROSPECTIVE PAYMENT SYSTEM SO THAT PAYMENTS ARE BASED ON A DRG-SPECIFIC, BLENDED RATE OF HOSPITAL-SPECIFIC AND FEDERAL COMPONENT PRICES.

OR

- o AMENDING THE PROSPECTIVE PAYMENT SYSTEM SO THAT PAYMENTS ARE BASED ON 50% ON HOSPITAL-SPECIFIC COSTS AND 50% ON REGIONAL AVERAGE COSTS.

If Congress accepted either of these proposals, equity across hospitals would be advanced during the time research was being conducted to identify additional adjustments necessary for a fair, formula-based prospective payment system.

The Phase-In: Impact of a Freeze

The Reagan Administration's 1986 budget proposes a freeze on DRG prices. This is particularly controversial because the so-called freeze is really a reduction for many hospitals, a fact that I would like to illustrate. Table 1 shows the phase-in of prospective payment for a hospital with a July 1 fiscal year. The proportion of the payment based on hospital specific costs declines on July 1 of each year and the ratio of regional and national prices changes on October 1 of each year. Thus, a July 1 hospital has six different prices across the three year transition period.

Table 2 takes real data from an actual COTH member hospital which was selected because of the quality and accuracy of its historical DRG data. The hospital-specific, regional, and national prices shown at the top of the table have been fully adjusted to include the original area wage index and the present resident-to-bed adjustment. The bottom portion of the table shows the amount this hospital would be paid for a DRG with a weight of 1.00 if the prices in place on October 1, 1984 are frozen until September 30, 1986. Simply stated, a one year freeze in the prices with a continuation of the phase-in means this hospital's payment for this case declines from $6,110 per case on October 1, 1984 to $5,341 per case on July 1, 1986 -- a reduction of almost $800 per patient.

The phase-in circumstances vary for each hospital depending upon the relationship between its hospital-specific, regional, and national prices at the point of any freeze. To avoid making a freeze a reduction, the AAMC recommends:

> TEMPORARILY HALTING THE PHASE-IN AT 50% HOSPITAL-SPECIFIC AND 50% FEDERAL COMPONENTS TO ALLOW TIME FOR HOSPITALS, THEIR ASSOCIATIONS, HCFA, AND CONGRESSIONAL COMMITTEES TO ANALYZE

THE IMPACT OF MOVING TO THE PRESENTLY-DESIGNED, FULLY IMPLEMENTED PROSPECTIVE PAYMENT SYSTEM.

It should be noted that the AAMC testified before the Subcommittee last month that it opposes a freeze. The Association still opposes a freeze.

The Resident-to-Bed Adjustment

When prospective payment was being considered, the Congressional Budget Office testified before this Subcommittee and compared the system's impact on teaching and non-teaching hospitals. Table 3 reproduces CBO's February, 1983 impact assessment. It shows 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. It should be noted that this impact assessment assumed the original or single resident-to-bed adjustment.

Why would teaching hospitals do so poorly? I believe four factors contributed heavily to this adverse impact:

o First, when HCFA set the regional and national average prices, they computed the average on a hospital-weighted, rather than a case weighted, basis. Therefore, in computing the average, a major teaching hospital admitting 10,000 Medicare cases had the same impact as a small suburban hospital with 750 Medicare admissions. The effect of the use of a hospital-weighted average is that the "price norm" (i.e. average price) for urban hospitals is a 255 bed hospital. In the Council of Teaching Hospitals, the average hospital has 562 beds. The scope of services and therefore average costs of a hospital generally vary with bed size. This was recognized in the

TEFRA limits where hospitals were compared using bed size groups. Table 4 shows the standarized TEFRA limits for urban hospitals. The table shows larger hospitals had higher limits. HCFA's use of an approach that sets prices approximating the costs of a 255 bed hospital hurt teaching hospitals.

- Secondly, the DRGs have only 468 categories for recognizing differences between patients. If each hospital received an equal variety of patients in each DRG, 468 categories would not cause serious problems. Teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases. Without such an adjustment, teaching hospitals are hurt by an average pricing system. Unfortunately, no easily implemented system to adjust the DRG for the difference in severity was available in 1983 and none is yet available.

- Third, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and central city hospitals have higher average costs than suburban hospitals. These costs include differences such as increased security and social services departments. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payment.

- Finally, when HCFA estimated the factor for the resident-to-bed adjustment, they included two variables in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated and teaching hospials were adversely impacted until Congress doubled the computed adjustment.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Thus it helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception.

The resident-to-bed adjustment is a crucial equity factor in prospective payment. It should be retained, but it should be properly estimated. An unbiased and more defensible adjustment can be obtained if the adjustment is re-estimated with an equation based only on the factors used in determining DRG prices and with up-to-date, accurate data. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING CURRENT HOSPITAL RESIDENT AND BED DATA; UP-TO-DATE, CORRECTED HOSPITAL CASE MIX INDICES; CORRECTED WAGE INDICES; AND A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING HOSPITAL DRG PAYMENTS.

Recognizing the importance of the adjustment to teaching hospitals, the AAMC hired Judith Lave, Ph.D., HCFA's former research director, to conduct an independent review of the history, development, and computation of the adjustment. In her paper, Dr. Lave reports the resident-per-bed adjustment would have been set at 9% per .1 resident per bed if the analysis had used only variables incorporated in the prospective payment system. Recently, a similar re-estimate of the adjustment was made by the Congressional Budget Office. Their work is the most detailed and comprehensive empirical study of the Medicare costs of teaching and non-teaching hospitals I have seen to date.

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, costs reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly described in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated (or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes only Medicare's share of expenses incurred by the cost center and allocated overhead.

Reducing Medicare's share of the costs of medical education in the hospital will weaken graduate medical, nursing, and allied health education programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IS STRONGLY OPPOSED TO ANY CHANGE OR REDUCTION IN THE PASSTHROUGH FOR DIRECT MEDICAL EDUCATION COSTS UNTIL A COMPREHENSIVE ASSESSMENT OF FINANCING GRADUATE MEDICAL EDUCATION IS COMPLETED AND FULLY CONSIDERED.

The AAMC urges this Subcommittee to immediately ask the HCFA Administrator to halt the Administration's plan to implement by regulation a freeze in the direct medical education passthrough.

Disproportionate Share Providers

Hospitals serving a disproportionate share of the poor face two significant problems. First, within a DRG, indigent patients tend to use more services than non-indigent patients. This often results from waiting longer to seek medical care, or because of chronic illnesses and complicating conditions, or from the absence of a suitable home environment to which the patient can be discharged. Thus, indigent Medicare patients tend to be more costly than non-indigent Medicare patients. Secondly, non-Medicare indigent patients who do not pay their bills must have the costs of their care subsidized by other patients, private philanthropy, or government payments. Some argue that Medicare should help underwrite the care of non-Medicare indigent, at least where the hospital has few paying patients.

The AAMC believes the two facets of the problems confronting disproportional share providers must be separately addressed. Congressional committees examining the disproportional share issue must determine whether they wish to amend the prospective payment system to incorporate: (1) the higher costs of indigent Medicare patients, or (2) a payment to hospitals to assist them in caring for indigent non-Medicare patients, or (3) both of the above.

Some analysts have hypothesized that the resident-to-bed calculation may provide some adjustment for the greater expense of indigent Medicare patients in teaching hospitals; however medical education activity is not always a good estimator of the cost burden of indigent patients. Some teaching hospitals care for a disproportional number of indigent patients; others do not. In this circumstance, a separate indigent care adjustment should be established to acknowledge the cost impact of the more severely ill indigent patients using a regression model similar to that used for the resident-to-bed adjustment.

I must caution this Subcommittee that the data for an analysis of indigent care presents several problems. Medicaid coverage varies across the states and Southern states are disadvantaged if the proportion of Medicaid patients is used in the analysis. Hospital charges or deductions for bad debt and charity care are also hard to interprete because it incorporates the hospital's mark-up ratio. Finally, state and local appropriations must be considered in determining the hospital's need for an indigent care subsidy. In spite of these difficulties, it is important to assist hospitals who care for poor patients lest these hospitals and their communities become the victims of a price competitive strategy to contain hospital costs.

Wage Index Adjustments

The wage index numbers used since the beginning of prospective payment are based on incorrect data. The 1984 Tax Reform Act requires HCFA to obtain correct data, recompute the index numbers, and retroactively adjust PPS payments back to October 1, 1983. For hospitals with an increasing index this is not a problem. For hospitals with a declining index, the hospital will have to simultaneously adjust to a lower payment rate and return the past overpayment. This could create major financial problems and threaten hospital viability. Moreover, the retroactive adjustment suggests that corrections in PPS data should be applied back to the start of the program. This is inconsistent with the prospective nature of the system. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS CORRECTING THE WAGE INDEX NUMBERS USED IN PROSPECTIVE PAYMENTS BUT RECOMMENDS AMENDING THE LAW TO ELIMINATE THE CURRENT REQUIREMENT THAT THE NEW INDEX NUMBERS BE APPLIED RETROACTIVELY TO OCTOBER 1, 1983.

Conclusion

The AAMC supported the prospective payment concept in 1983. Our members still favor a prospective system over an intrusive regulatory system. If the Medicare prospective payment system is to provide hospitals with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the cost of various types of hospitals should be recognized. The AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment system than that recommended in the Administration's budget proposal.

Table 1

PPS Phase-in for Hospital With July 1 Fiscal Year

	Blend		
Fiscal Period	Hospital Specific	Regional	National
7/84 - 9/84	75	25	0
10/84 - 6/85	75	18.75	6.25
7/85 - 9/85	50	37.5	12.5
10/85 - 6/86	50	25.0	25.0
7/86 - 9/86	25	37.5	37.5
10/86 - 6/87	25	0	75
7/87	0	0	100

Table 2

PPS Payments with a Price Freeze and Phase In

	Amount
Hospital Specific Price	$6,467
Regional Average Price	5,111 (includes resident adjustment)
National Average Price	4,821 (includes resident adjustment)

Fiscal Period	Hospital Specific	+	Regional	+	National	=	DRG Payment
10/84 - 6/85	75%(6467)	+	18.75%(5111)	+	6.25%(4821)	=	$6110
7/85 - 9/85	50%(6467)	+	37.50%(5111)	+	12.5%(4821)	=	5753
10/85 - 9/86	50%(6467)	+	25%(5111)	+	25%(4821)	=	5717
7/86 - 9/86	25%(6463)	+	37.52%(5111)	+	37.5%(4821)	=	5341

Table 3

ESTIMATED AVERAGE PENALTIES AND BONUSES UNDER THE ADMINISTRATION'S PROPOSED DRG-BASED PAYMENT SYSTEM, BY TYPE OF HOSPITAL a/

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements b/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements c/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements d/
All Hospitals	100	0 e/	61	+23	39	-12
Bed Size						
Less than 100	49	+23	80	+35	20	-10
100-299	34	+2	50	+21	50	-11
300+	17	-6	30	+17	70	-13
SMSA						
SMSA	52	-4	43	+20	57	-13
Non-SMSA	48	+19	81	+29	19	-6
Region						
Northeast	15	-4	45	+19	55	-12
North Central	28	-4	60	+21	40	-13
South	37	+8	72	+26	28	-9
West	20	-2	57	+23	43	-13
Teaching Status						
Teaching	18	-7	29	+18	71	-13
Nonteaching	82	+7	69	+24	32	-10
Ownership						
Nonprofit	57	-2	55	+20	45	-12
Government	31	+9	78	+29	22	-12
Proprietary	12	-1	48	+22	52	-13

SOURCE: Preliminary CBO estimates based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

b. Average calculated for all hospitals.

c. Average calculated for hospitals that would gain.

d. Average calculated for hospitals that would lose.

e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments to others.

Table 4

Medicare Limit on Operating Costs Under TEFRA
for Hospitals Located in Urban Areas

Bed Size	Labor	Non Labor	Total
	Componts of Limits		
Less than 100	$2,394.70	$616.48	$3,011.18
100 to 404	2,776.13	731.05	3,507.18
405 to 684	2,897.76	765.57	3,663.33
685 and above	3,199.78	881.65	4,081.43

Chairman STARK. Dr. Mongan.

STATEMENT OF JAMES MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Dr. MONGAN. Mr. Chairman, I am Dr. Jim Mongan, executive director of Truman Medical Center. I am here representing the National Association of Public Hospitals. Mr. Chairman, you know from prior testimony about public hospitals. You know about the special role we play in the Nation's health system. You know from prior testimony that public hospitals are being unfairly squeezed by the DRG system, with many of us facing actual cuts in Medicare reimbursement below our current levels.

I would like to use this brief second opportunity to testify before the committee not to retread this old ground, but rather to focus on two things. First, the reasons why the DRG system is critically flawed, and second, two actions that this committee can take to assure a more equitable payment system. I will refer to a series of charts attached to my prepared testimony.

Let me begin with a brief description of the flaws in the DRG system which severely penalize public hospitals. There are a number of these, as illustrated in my first chart. First, the system does not take into account differences in the severity of illnesses within a given DRG, nor does it take into account appropriately the existence of multiple diagnoses, complications and multiple procedures prevalent in our patients.

Second, evidence mounts that PPS does not take into account suburban-urban wage differentials. Third, PPS does not account for differences in case mix or other extraordinary circumstances within facilities. Fourth, PPS does not take into account the very real costs of caring for a disproportionate number of poor patients.

Mr. Chairman, I assure you these flaws are not technical quibbles. They are flaws with huge reimbursement implications. These have been masked in the first year of the program because only 25 percent of a facility's payment has been based on these regional and national rates.

If we continue to move blindly to a fully implemented national rate, you will see hundreds of millions of dollars sloshing from one region to another and millions of dollars moving from some hospitals in your districts to other hospitals in your districts, not because they are more or less efficient, but because of the flaws in this national rate.

There simply is no evidence that these huge revenue shifts will be going from less efficient institutions to more efficient institutions. Mr. Chairman, having described our concerns, I would like to turn to our two recommendations for improving the system. Our first would be to freeze the transition to a national rate until solutions are developed to its serious flaws.

I have heard only one argument against freezing the transition. That is that it would somehow emasculate the incentive for cost containment and move us back to the inflationary evils of cost reimbursement. Stated most simply, that is nonsense. It is after all the existence of a known prospective rate that gives administrators the incentive to control costs.

That incentive isn't weakened regardless of whether the prospective rate is a national rate or a 50-50 blend which includes an institution specific rate. Just look at the record. The enormous savings achieved this past year were achieved in a year when 75 percent of the payment was institution specific. Why people believe that the many hospitals which will receive unearned windfalls under a fully national rate will have more reason to be efficient simply eludes me.

I would strongly urge you to freeze the transition to a national rate until this system can be improved and corrected.

My second recommendation is that the committee move now to deal with at least one of the flaws in the DRG system, its failure to recognize the cost of providing care to disproportionate share of the poor. The next chart summarizes results of an urban institute study.

It shows these costs are real. As the chart shows, in this group of hospitals studied, costs were nearly 20 percent higher in those facilities providing a high volume of care to the poor. Most importantly, as the next chart shows, the committee now has solid data from all the major parties involved—HCFA, AHA, and CBO—which shows all three of these groups are very close in their estimate of the extent of these additional costs.

With this kind of agreement, there simply is no reason to delay. That is better data on this issue than on 90 percent of what the Congress often has available when it legislates on other issues.

As chart 5 shows, there remain some implementation issues in drafting a disproportionate share adjustment, but they can be easily addressed. On the three major issues, we feel as follows:

First, we believe the adjustment should be based on the broadest measure of disproportionate share, including Medicaid, charity, and bad debt, as this gives the truest profile of an institution's burden.

As the next chart shows, since Medicaid covers only slightly over half the poor, Medicaid alone is bound to be a poor surrogate. The next chart, more importantly, analyzes the hospitals heavily involved in care to the poor. Public hospitals seem similar to private hospitals in their percentage of Medicaid patients, but public hospitals have much higher percentages of charity care and bad debt.

Second, we believe the adjustment should be on a sliding scale, depending on the percentage of poor patients served by the institution.

Finally, we believe some reasonable threshold might be considered to focus the adjustment on those hospitals with a substantial burden. Chart 8 shows that only a handful of hospitals provide more than 6 or 7 percent charity care and bad debt.

Mr. Chairman, to summarize, I would urge the committee to take two actions. Freeze the transition to a national rate and legislate a specific disproportionate share adjustment. These two steps are critically important to our Nation's public hospital, whose special mission to the poor makes them at the same time our most valuable and most vulnerable health care institutions.

Thank you.

[The prepared statement follows:]

STATEMENT OF JAMES MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEMORIAL MEDICAL CENTER, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. Chairman, members of the Subcommittee, I am James Mongan, Executive Director of Truman Memorial Medical Center, Kansas City, Missouri, a 608-bed public teaching hospital. I also serve as a member of the Board of Directors of the National Association of Public Hospitals, and I am accompanied this morning by Larry S. Gage, President and General Counsel of that organization. NAPH consists of 50 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

We welcome the opportunity to testify before the Subcommittee this morning, to discuss several specific issues regarding the implementation of the Medicare Prospective Payment System. In the interest of time, and because we have testified recently on the more general situation of public hospitals in America today, I will present my testimony this morning in outline form, with reference to several specific charts and tables which I have included at the end of my prepared statement.

I. Public Hospitals in Our Nation's Major Metropolitan Areas, and Other "Disproportionate Share" Hospitals, Are Already Being Adversely Affected by The PPS System.

A. The current budget proposal would reduce the projected Medicare revenues of Truman Medical Center by over $1 Million next year. In fact, the Administration proposal, combined with a move to the National rate would actually slash our Medicare payments to a level 4% below what we are currently paid.

B. Most NAPH members are also major teaching hospitals, and thus have benefitted to a certain extent from the indirect medical education adjustments. However, CBO and other analysts have clearly found that, among major teaching hospitals, government-owned hospitals have significantly lower operating margins than private teaching hospitals and would be much more seriously affected by any major reduction in those payments.

C. Most analysts now agree that there are several deficiencies in the present PPS methodology that contribute to the serious inequities of the system for disproportionate share hospitals. Those include, among other factors, the inability of the PPS system by itself to adequately account for: (Chart 1)

1. Differences in severity of illness for patients in certain DRGs, including patients with multiple diagnoses or who require multiple procedures.

2. Differences in the costs incurred by hospitals in inner cities, as opposed to those in suburbs, including wage differentials and other factors.

3. Differences in case-mix among hospitals, particularly teaching hospitals.

4. Extraordinary circumstances experienced by hospitals during or after their PPS-base year, which may require appeals or exceptions.

5. The special situation and extra cost experienced by hospitals serving significantly disproportionate numbers of low-income patients.

D. The Congress in general, and the members of this Subcommittee in particular, clearly understand these inequities, and you have attempted on several occasions to address these flaws in the PPS system. The mechanisms you have enacted include outright exemption of certain hospitals, the indirect and direct teaching adjustments, a general appeals mechanism, and a specific adjustment for "disproportionate share hospitals". Unfortunately, HHS has refused to permit appeals or exceptions in many of the areas spelled out by the Congress as requiring attention. With regard to disproportionate share hospitals, this includes their refusal even to develop definitional criteria and identify hospitals meeting that criteria, as the Congress demanded last year. We believe you must now remedy this refusal by HHS to acknowledge and address PPS inequities. You can accomplish this: first, by slowing down the present rate of PPS implementation; second, by paying careful attention to the appeals process generally; and third, by enacting an explicit adjustment for disproportionate share hospitals.

II. All Major Participants Now Agree That Metropolitan Area Public Hospitals, and Other "Disproportionate Share" Hospitals, Have Higher Medicare Costs Per Case, in Direct Relation to their Proportion of Low-Income Patients.

A. (Chart 2) The Urban Institute has found that urban hospitals providing a high volume of care to the poor have higher costs per in-patient day, and are more likely to have a negative net operating margin, than low volume hospitals.

B. (Chart 3) Perhaps more significantly, AHA, CBO, DCHA and internal HCFA studies all demonstrate that higher Medicare costs are directly related to serving low-income patients. Even though each of these parties used somewhat different measures and criteria, their studies have come to almost identical conclusions with regard to the relative proportion of the impact on Medicare costs.

C. It is also important to note, as ProPAC did in our April report, that regression analyses have been used to show that this impact is clearly separate from the impact of such factors as teaching status, bed size, wage differentials and urban or rural location.

D. Despite this independent correlation, several observers have suggested that the indirect teaching adjustment is intended to compensate at least in part for "disproportionate share status". It is therefore also important to underscore the findings of AHA, AAMC and others that only about half of all teaching hospitals can be considered "disproportionate share" providers.

E. Similarly, we believe there are also disproportionate share hospitals without teaching programs, who may well be in the worst shape of all under the PPS system.

F. Finally, while we can quantify the impact of being a "disproportionate share hospital" on higher Medicare costs, as with other flaws in PPS, we cannot yet precisely identify what causes those higher costs. However, we believe we can point the Committee to a number of extra services we provide and costs we incur in four principal areas. (Chart 4)

III. It Should Therefore be Clear, As ProPAC and Almost Every Other Party Has Urged, That Implementation Of a Concrete Statutory "Disproportionate Share Hospital" Adjustment is Necessary To Correct Certain Inequities in the Present System.

Moreover, such a step is essential if Congress chooses to make other reductions in the Medicare Program this year, such as a reduction in the indirect teaching adjustment. In that regard, several issues remain to be addressed: (Chart 5)

A. How do you most accurately and consistently measure the proportion of low-income patients?

1. Medicaid only is an inadequate measure of the proportion of "low income patients". (Chart 6)
2. Medicaid, plus a factor such as "charity care and bad debts", to account for uninsured low-income patients, is more accurate and equitable. (Chart 7)
3. While the quality of self-reported bad debt and charity care data, such as the AHA Annual Report, may be a problem, we believe it is not an insoluble one.
4. For example, if necessary for the sake of uniformity, we see no reason why hospitals desiring an adjustment could not be asked to fill out an additional brief cost report, using consistent reporting principles written into the statute.

B. Once you have identified an appropriate measure, what kind of adjustment should be provided?

1. We believe a continuous or sliding-scale adjustment, which would provide a higher adjustment for a more disproportionate hospital, is preferable to a single fixed adjustment which might be provided to all hospitals meeting a particular definition of "disproportionate share".
2. If a sliding-scale is adopted, the question remains as to the most appropriate threshold for triggering a hospital's initial entitlement (e.g., the national average, or some higher level of low income effort). Put another way, how many hospitals should be eligible for such an adjustment? (Chart 8)
3. What should be the actual level (or amount) of the adjustment? (E.g., permit an increased payment on the federal portion of .08% for each 1% increase above the national average in a hospital's proportion of low-income patients, as the studies outlined above might indicate).
4. What should be the total cost of this adjustment to the Medicare Program? (E.g., AHA estimates that an adjustment based on their data might cost about $220 million in FY 1986.)

We do not have answers yet to all of these questions, but we do not believe answers will be difficult to find. We look forward to working with you on this important matter, and we will be happy to answer any questions you may have.

CHART 1

PPS Alone Does Not Adequately Account for:

- Severity of Illness
- Multiple Diagnoses
- Multiple Procedures
- Inner City vs. Suburbs
- Differences in Case Mix
- Extraordinary Circumstances
- Disproportionate Share of Low Income Patients

CHART 2

Disproportionate Share Hospitals Have Higher Costs (100 Largest SMSAs)

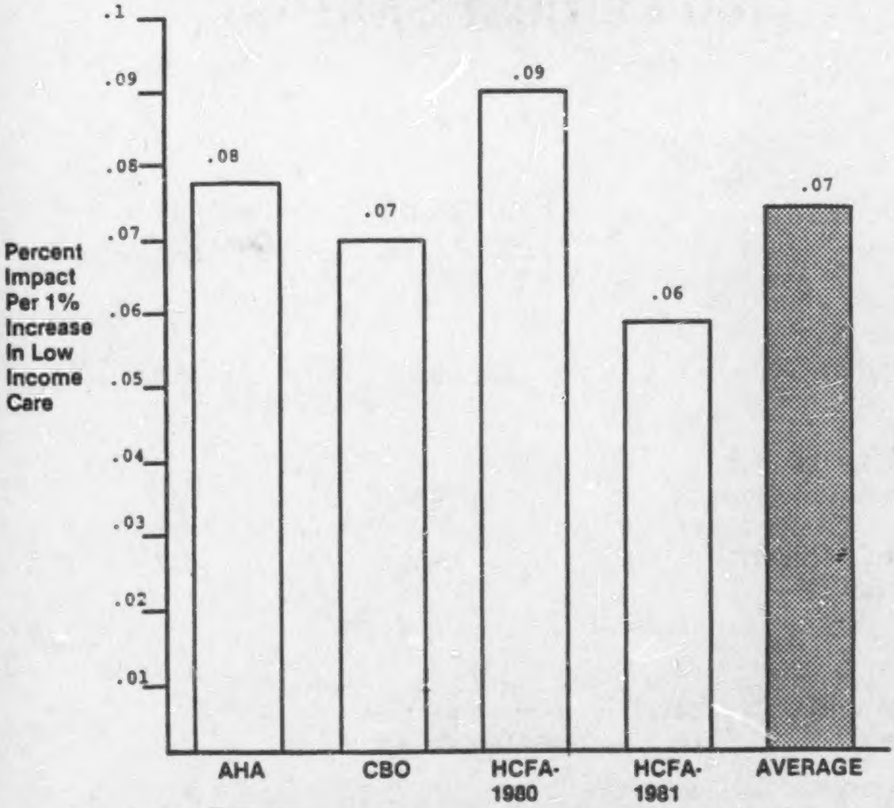
	High Volume Care to Poor	Low Volume Care to Poor
Cost Per Inpatient Day	$277.05	$235.14
Bad Debt & Charity Care as Percent of Charges	10.9%	2.9%
Net Operating Margin	– 2.6%	+ 3.4%

"High Volume" > 13.54% } Medicaid, Bad Debt
"Low Volume" < 7.54% } and Charity Care

Source: Urban Institute

CHART 3

Impact of Serving Low Income Patients on Medicare Costs Per Case



Low Income Factors:

AHA: Medicaid, bad debt & charity as a percent of gross revenues

CBO: Medicaid, bad debt & charity as a percent of charges

HCFA: Medicaid, "self pay", and other governmental admissions.

CHART 4

What Services Account For Higher Costs In Disproportionate Share Hospitals?

- Need to Treat Sicker Patients
  - — Multiple Diagnoses
  - — Multiple Procedures
  - — Postponed Care
  - — Fewer Elective Surgeries
- Special Discharge Problems
  - — Lack of Long Term Care Beds
  - — Inadequate Home Setting
  - — More Chronic Illness
- Extra Services Needed
  - — Admission & Eligibility
  - — Security
  - — Translation
  - — Transportation
  - — Nutritional Services
  - — Prevention & Education
- Higher "Standby" Costs
  - — Ambulatory Care
  - — Shock/Trauma
  - — Specialized Tertiary Services
  - — Adolescent Pregnancy
  - — Poision Control
  - — Substance Abuse
  - — Psychiatric

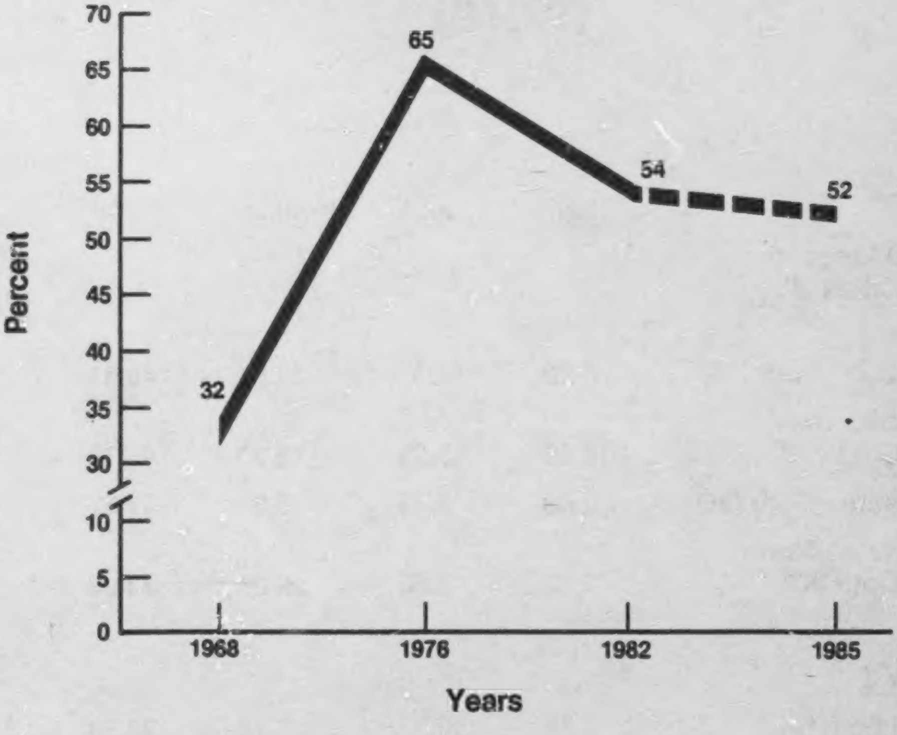
CHART 5

"Disproportionate Share" Adjustment: Implementation Issues

- Measuring "Low Income Patients"
  - Medicaid Alone
  - Medicaid, Bad Debt & Charity
  - New Cost Report?
- What Kind of Adjustment?
  - Fixed
  - Sliding Scale
- What Threshold for Hospital Entitlement?
  - How Many Hospitals?
- Level and Total Cost of Adjustment

CHART 6

Medicaid Recipients as a Percentage of the Poverty and Near Poverty Population* 1968-1985



* Less than $12,460 income for family of four, 1982

Source: Center for Health Policy Studies,
Georgetown University

CHART 7

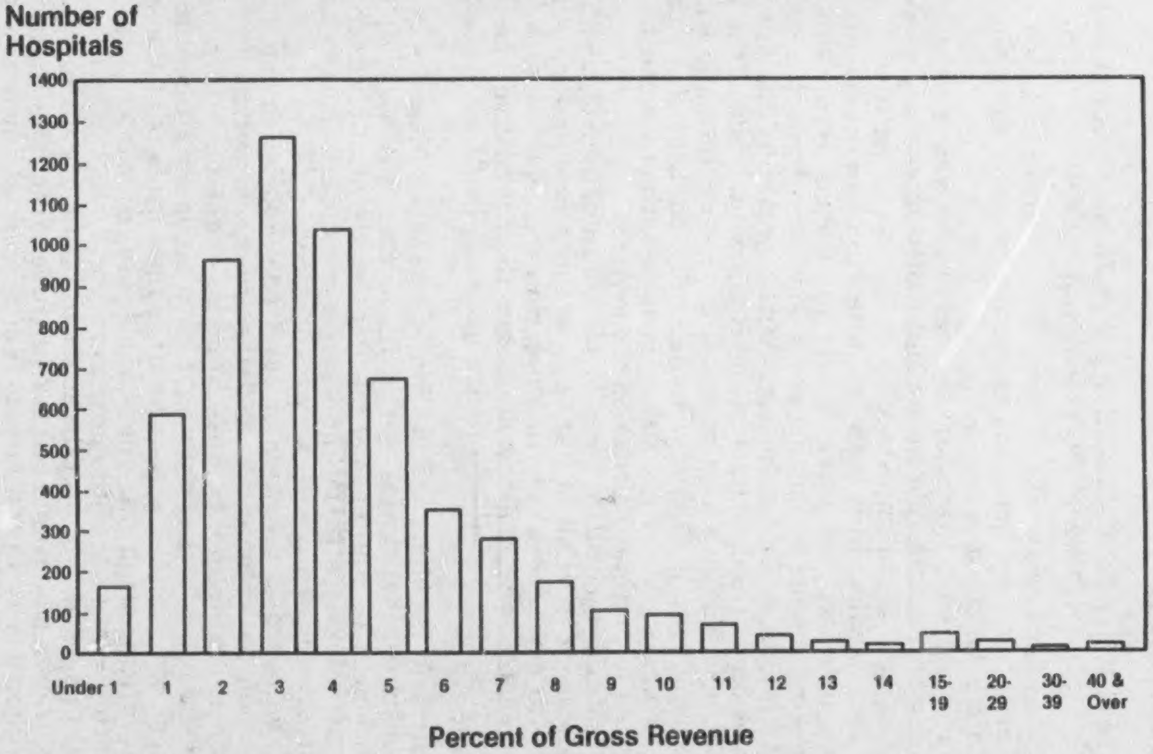
Characteristics of Hospitals Above the 90th Percentile of Care to the Poor (23% or more)

	Charity	Bad Debt	Medicaid	Total
100 Largest Cities (#'s)				
Public - Coth (44)	9.25	14.32	22.04	45.61
Public - Non-Coth (29)	13.63	15.26	18.29	47.18
Private - Coth (35)	2.49	3.45	25.39	31.33
Private - Non-Coth (82)	1.22	3.63	29.06	33.92
Rural				
Public (114)	1.28	10.77	12.49	24.53
Private (26)	1.55	3.74	23.25	28.55

Source: Urban Institute

CHART 8

Hospital Bad Debts/Charity Care as a Percent of Gross Revenue



Source: AHA

Chairman **Stark**. Thank you very much.

Mike Bromberg, executive director of the Federation of American Hospitals.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. **Bromberg**. Thank you, Mr. Chairman. I don't have any charts, but I did bring my executive counsel, Mary Grealy, in case there is hostile questioning.

I would say, first, our association, as you know, has testified many times here. We have continually supported prospective payment, and we continue to support the law as written.

That law has in it both fair rate increases and continued transition to a national rate. Clearly the system is working. Hospitals have responded by cutting costs. Medicare A, part A spending was $2.2 billion or 6 percent less than projected by the trustees of the trust fund. The hospitals in the country understood the law to be a contract. We have kept our part of the contract and the system is working, but if Congress unilaterally changes it or changes the rules of the game by freezing payments, then we can hardly be expected to continue to endorse the system.

Instead you will have calls for continuation of cost-based reimbursement with all of its perverse incentives and lost the opportunity to move forward with a program that is allowed the trust fund to remain solvent a decade longer than predicted just a year ago and has also benefited private insurers, beneficiaries, and employers.

Instead hospitals will be forced to reduce intensity of service to Medicare beneficiaries, cut staffs further, cut wages, postpone replacement of equipment and plant modernization, increase prices to non-Medicare prices, and perhaps increase charges to Medicare patients for noncovered services services.

The board of directors of our trade association has not taken a position on what to do about the transition period if it is coupled with a rate freeze, because to do so might have conveyed the impression to you that we would have accepted a freeze as equitable which we do not. Instead, we urge the members of the subcommittee to legislate a fair rate of increase in payments to assure the continued success of the program.

On pages 4, 5, 6, we talk about the issue of return on equity, Mr. Chairman. Our points are two or three. First, any change in return on equity prior to consideration of all capital payment issues would be premature, and inappropriate. Present rate of return on equity paid to for profit hospitals on Medicare is less than 12 percent, an after tax rate of about 7, considerably lower than that earned by industries of comparable risk.

The program also reimburses full cost interest associated with capital. For example, if one of our hospitals or any hospital borrows $10 million to finance a project, the interest is totally cost reimbursable. But, if, instead a for-profit institution finance the same $10 million project by borrowing $6 and raising $4 through investors, it should receive reimbursement for the cost of attracting equity capital.

To do otherwise would simply discriminate against divested capital in favor of borrowed capital and tell us to go out and leverage. I might add a very important point in reading some of the future points you are going to here. The rate of return on equity is a cost of capital. It is not a profit. I know of no economist in the country who considers it a profit. I can read a lot of quotes which I don't have time to do, but it is a cost, not a profit. I think that is important in terms of what some of the subsequent witnesses tell you.

In addition, investor-owned hospitals can't issue tax exempt bonds to finance capital, may not receive grants, may not receive tax deductible gifts. Therefore, without this return on equity we would be at a clear competitive disadvantage. Congress has already cut the return on equity by one-third in 1983, and use of debt capital by our hospitals which have severely restricted access to tax exempt financing could cost the Medicare program more than it currently pays us for return on equity for two reasons: one, because there would be higher interest rates due to higher debt, and, two, because we would be paying less taxes to the general treasury because of less payment from Medicaid.

So we would hope that that issue would be held off in terms of capital. In closing, I would like tc add two other quick statements on the wage index. I echo what some of the prior witnesses have said. We think the new wage index is better, should be implemented as quickly as possible, but without retroactivity.

On disproportionate share, we applaud the efforts of the subcommittee to address that issue. We would say it is a necessary adjustment that must be made. We think perhaps a longer term, more equitable solution would be to look at a severity index.

Finally, we would make the point we hope the committee does not think that by addressing disproportionate share that you are addressing the much bigger issue of indigent care which needs to be addressed desparately if our health system is to work.

In conclusion, we would simply say the prospective payment system, you have heard a lot about it today from a lot of witnesses, notwithstanding anything you have heard, is the single most effective cost containment program ever enacted. And we simply want to urge you not to undermine it by making the prices for next year inequitable.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

SUMMARY

The Federation of American Hospitals has supported and continues to support implementation of the prospective payment law as passed with fair rate increases and a continued transition.

Hospitals have responded to the new incentives of the prospective payment system by saving the Medicare program billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price.

Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing hospital payments, then hospitals can hardly be expected to continue to endorse the program. The Board of our association has not taken a position on the transition coupled with a rate freeze because to do so might convey the impression we might accept a rate freeze as equitable, which we do not. Instead we urge the members of the Subcommittee to authorize a fair rate of increase in hospital payments for Fiscal Year 1986 in order to ensure the continued success of the Medicare hospital prospective payment system.

Medicare's return on equity payment is identical in principle to the payment of interest expenses incurred by not-for-profit hospitals. Return on equity like interest is a cost. The Medicare return on equity and other capital issues should be analyzed as part of the development of a prospective payment plan for Medicare capital payments for all hospitals.

The new wage index developed by HHS should be prospectively implemented and not made retroactively effective. The Department should continue to refine the wage index to reflect accurately the labor costs of individual hospitals.

We applaud the efforts of the Subcommittee to address the needs of hospitals serving a disproportionate share of low-income patients and Medicare Part A beneficiaries and hope they will develop appropriate criteria to determine which institutions are eligible for a "disproportionate share" adjustment. A long term solution to this problem may be the development of an accurate severity index. Furthermore, Congress must in the near future address the broader issue of uncompensated care affecting all hospitals.

STATEMENT

The Federation of American Hospitals is the national association of investor-owned hospitals and health care systems representing over 1,200 hospitals with over 140,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the ony hospital serving the population.

DRG RATES AND TRANSITION

The Federation of American Hospitals has supported and continues to support implementatin of the prospective payment law as passed with fair rate increases and a continued transition. Hospitals have responded to the new incentives of the prospective payment system by saving the Medicare program billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price. Due to the more careful management of admissions, labor costs and utilization of facilities, ths hospital industry has succeeded in bringing hospital costs down dramatically. In 1984, the annual rate of increase in hospital expenditures was only about 4.5%, or approximately the same as the general inflation rate. clearly, the Medicare hosptial prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal 1984, for example, acutal Medicare Part A spending was $2.2 billion, or 6% less than originally projected by the trustees of the Hospital Insurance Trust Fund.

Hospitals have demonstrated that with the appropriate incentives they will vigorously cut costs. However, the right incentives under this system include an equitable rate of increase in payments from year to year. If hospitals feel their only reward for reducing hospital expenditures is to receive a freeze in future payments, there remains little reason for their continued support of the program.

Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing hospital payments, then hospitals can hardly be expected to continue to endorse the program. Instead, you will have calls for the continuation of cost based reimbursement, with all of its perverse incentives and lose the opportunity to move forward with a program that has allowed the Medicare Trust Fund to remain solvent a decade longer than predicted just a year ago and has benefited private insurers, beneficiaries and employers as well.

A freeze in hospital payments will not reward hospital managers who have cut their costs by working with their staffs, physicians and patients to adapt to the new payment system. Instead hospitals will be forced to reduce their intensity of services to Medicare beneficiaries, cut their staffs and wages, postpone replacement of equipment and plant modernization, increase prices to non-Medicare patients and increase charges to Medicare patients for non-covered services.

We believe that a rate increase at least as much as that recommended by the Prospective Payment Assessment Commission should be enacted by Congress. The Federation of American Hospitals believes the hospital industry should accept a fair share of responsibility in any attempt to reduce the Federal deficit; however, a freeze in hospital payments goes far beyond any sense of fairness and proportion and should be rejected.

The Board of our association has not taken a position on the transition coupled with a rate freeze because to do so might convey the impression we might accept a rate freeze as equitable, which we do not. Instead we urge members of this Subcommittee to legislate a fair rate of increase in hospital payments to ensure the continued success of the Medicare hospital prospective payment system.

MEDICARE RETURN ON EQUITY

Congress, in enacting the Medicare Hospital Prospective Payment System, did not include capital costs, but continued to reimburse hospitals for capital expenditures on a cost basis. Congress also directed the Secretary of HHS to complete a thorough review of the methods by which capital, including return on equity (ROE), could be incorporated into the prospective payment system. Any change in return on equity payments prior to consideration of a prospective payment system for all capital payments to hospitals would be inappropriate.

The issue presented here is whether to reduce or eliminate Medicare return on equity payments to the owners of investor-owned hospitals for the use of their equity capital to finance hospital buildings and equipment used by Medicare patients.

Medicare currently pays a rate of return on equity of less than 12%, a rate considerably lower than that earned by industries of comparable risk. The Medicare program also reimburses the full interest expenses associated with capital expenditures by hospitals. For example, if a hospital borrows $10 million to finance a project, the interest on the entire amount is reimbursable. If an investor-owned hospital finances the same $10 million project by borrowing $6 million and raising $4 million through an equity offering, it should receive reimbursement for the cost of the equity capital. To do otherwise would simply discriminate against invested capital in favor of borrowed capital.

Medicare's ROE payment is identical in principle to the payment of interest to people who have loaned money to not-for-profit hospitals. Like interest, return on equity itself is a cost. Both interest and return on equity are compensation to the suppliers of capital for the right to use it. Failure to pay interest on debt would be considered using somebody else's money without paying them for it. Failure to pay return on equity has the same effect.

A further element is the income tax liability that is the responsibility of the investor-owned hospital. It pays a corporate federal and state income tax on its net income which reduces the pre-tax Medicare return on equity payment by approximately 41 percent. Investor-owned hospitals also pay state and local property taxes. Investor-owned hospitals cannot issue tax-exempt securities to finance capital expansion and may not receive grants and tax deductible gifts. Therefore, without a return on equity payment, investor-owned hospitals would be at a clear competitive disadvantage.

The owners of debt capital and the owners of equity capital are identical in that both are suppliers of an essential resource, and like supplier of another essential resource, labor, they are entitled to a return for the use of that resource. To eliminate the ability of investor-owned hospitals to recoup equity costs from Medicare, would arbitrarily single out and penalize one segment of the hospital industry.

The capital assets of the investor-owned hospitals represent a $20 billion investment in our health care system. Congress has already cut reimbursement for return on equity by one third, during enactment of the prospective payment system, in 1983. If their ability to raise equity capital in a competitive environment is impaired, new capital will not be available for needed future investment. Use of debt capital by investor-owned hospitals, which have severely restricted access to tax exempt financing, could cost the Medicare program more than it currently reimburses for return on equity.

The Medicare return on equity and other capital issues are complex parts of an important area of reimbursement and should not be changed prior to careful study. Return on equity should be analyzed, as directed by Congress, as part of the development of a prospective payment plan for Medicare capital payments for all hospitals.

WAGE INDEX

The new wage index developed by the Department of Health and Human Services appears to reflect more accurately hospital labor costs, particularly for hospitals using part time employees. The HHS data base represents a more complete survey of hospitals. The new wage index also appears to lessen the effects of the transition to a national prospective rate, after revision of the standardized amounts to account for the changed wage index.

We believe the new wage index should be prospectively implemented this coming fiscal year, and not made retroactively effective. Hospitals cannot plan effectively for retroactive changes in payment. Retroactive application of the new wage index could severely undermine the fiscal predictability critical to the prospective payment system.

The Department of Health and Human Services should continue efforts to refine the wage index so that it accurately accounts for prevailing wages in a hospital's particular labor market area. The Deficit Reduction Act of 1984 directed the Secretary to develop criteria by which an adjustment could be made in a hospital's wage index if it did not accurately reflect the hospital wage levels in the labor market area serving the hospital. We encourage the Secretary to develop the criteria, to ensure that indivdiual hospitals receive a fair wage index adjustment.

DISPROPORTIONATE SHARE

We applaud the efforts of the Subcommittee members to address the needs of hospitals serving a disproportionate share low-income patients and Medicare Part A beneficiaries as called for in the original prospective payment legislation. We hope the Subcommittee, in conjunction with the Department, will develop appropriate criteria to determine which institutions meet the definition of "disproportionate share" hospitals incurring higher costs due to their patient population. However, while this may prove to be a necessary short term adjustment, the development of an appropriate measurement of severity would serve as a long term and more equitable solution for all hospitals serving a population requiring greater intensity of services. We would encourage the Department to develop a severity index rather than developing a complex system of exceptions and adjustments for select hospitals. Since factors such as bed size, urban area population, and proportion of low income patients served are useful mainly as proxies for patient health status, the adjustment of payment rates by an objective, direct measure of health status would make the need to use such proxies unnecessary.

We would further point out that solving the problem of "disproportionate share" hospitals does not address the larger issue of uncompensated care, a burden borne by every hospital. The evolution of a competitive health care system intensifies the magnitude of the uncompensated care problem. Congress must turn its attention towards this critical matter and realize that the adjustment in Medicare payments for disproportionate share hospitals does not address the issue of hospitals providing care without receiving payment from any source.

CONCLUSION

The Medicare Hospital Prospective Payment System is the most effective cost containment program ever enacted, successful beyond anyone's expectations. Last month we testified before this Subcommittee on the Administration's budget proposals for Fiscal Year 1986, specifically the freeze in hospital payments. We asked this Subcommittee to enact a fair rate increase in payments to hospitals by urging the House Budget Committee to reduce its target for Medicare cuts.

We again urge the members of this Subcommittee not to undermine the success of this program through arbitrary, inequitable reductions in payments to hospitals.

Chairman STARK. Thank you very much.

Mr. Bentley, would you agree that accounting for the cost of medical training insofar as translating that through to the cost of an appendectomy or anything else, is fairly complex and not as imperative as some calculations would make it?

Mr. BENTLEY. I think the best evidence of your question is the fact that there are some costs which can be relatively easily determined by accounting formula.

Chairman STARK. Salaries.

Mr. BENTLEY. Those are direct cost pass-through. The indirect adjustment most likely includes some other impacts, economic impacts on the institution.

Chairman STARK. A lot of windage in getting ahead on that.

Mr. BENTLEY. It is very difficult to say what part of the indirect adjustment is severity or medical education or different input factors.

Chairman STARK. What do we get out of that, we the taxpayer? I mean what do we get from paying for medical education?

Mr. BENTLEY. Let me back up and give a little history. Historically, the hospitals have functioned such that they have supported a variety of products through patient service revenue—absent other sources of revenue for multiple product.

Medical education is one of those products—the clinical education of physicians, nurses, and allied health specialists. What we primarily get, is that in a field of endeavor in which clinical practice in the working environment is a key and necessary part of training, is a fully skilled independent practitioner. We have contributed to develop a supply of manpower that is available not only for the current generation of beneficiaries, but also for those who are coming on to the system.

Chairman STARK. Why shouldn't those folks pay for their own education?

Mr. BENTLEY. It is conceivable you could go to a system in which you asked physicians in training to pay entirely for their education.

Chairman STARK. That happens to engineers, lawyers and accountants. You can't question whether it is valuable, but it is a fact.

Mr. BENTLEY. I would note that the cost of their early professional training is included in the price of the firms they go to work for, whether it is General Motors, including early engineer training or law firms, including training of young lawyers.

Chairman STARK. So we don't pay any tax dollars to help them do that, do they? The law firms have less profit or——

Mr. BENTLEY. That's correct. And in the price competitive system towards which we are evolving, where only about 150 hospitals do half of all the training, those 150 hospitals, as well as the other about a thousand hospitals engaged in training will be disadvantaged.

We have a highly concentrated educational program in a limited number of institutions. They, we believe, cannot deliver the same care for the same price and continue their educational mission.

Chairman STARK. Why wouldn't it be in the best American tradition to just say this. Recognizing it may create a little cash flow problem for the brain surgeon who has to pay for is or her own education, why shouldn't we just say let's let the medical schools charge the full cost. Don't worry about how we shuffle it around from hospital to hospital and then put an excise tax on physicians' fees for the rest of their lives, pay a point, dump it into some kind of trust fund and let them fund education.

If they don't make as much money, go into public service, fine. They don't pay as much. if they make $500,000 a year, they pay more than the pediatrician who doesn't make as much. Why wouldn't that be a fairer system?

Mr. **Bentley**. I think what we have done in that series of questions is change the issue from what should we pay to how we should pay it.

Chairman **Stark**. You are getting both ends of the teeter-totter in the air at the same time.

Mr. **Bentley**. I understand. If the cost is to be repaid either through loans and therefore, the fees physicians have to charge or through some kind of tax that would be included on their future earnings, we certainly are transferring on to future generations a cost of training in the current environment.

I don't think we are decreasing that cost. It may be more difficult to identify, but I think we better be careful we don't kid ourselves that somehow we have lowered the cost of the training.

Chairman **Stark**. No; I don't think we have lowered the cost. It is a question of who pays for it.

Mr. **Bentley**. There are a whole series of alternatives that I think can be debated. Each have advantages or disadvantages. I would note you raised the first question about a loan, at a time when a number of Members of the Congress are interested in stimulating people in fields of primary care, in areas which are underserved. These are economically disadvantaged both in terms of average income and in terms of lifetime income. If you require the student to borrow, you could stimulate people to go into subspecialty fields of surgery and medicine where earnings are higher which appears to be counter to a lot of people's thinking at this point.

Chairman **Stark**. I guess I would ask you and each of your colleagues on the panel, a question. It refers really to Dr. Mongan's testimony. Your third chart shows HCFA, CBO's and AHA's data. From the data that you had available to you, when you prepared the chart, and I assume the other gentlemen on the panel are familiar with that—do you think that there is adequate data there for this committee to go ahead and prepare some kind of disproportionate share legislation without feeling you would be too far out of the ball park absent anymore input?

Would you be comfortable with that, Dr. Mongan?

Dr. **Mongan**. As I indicated, I certainly feel the data are adequate to do that. I think you have it from three separate sources, major sources involved. It is quite strikingly similar in what it shows. Frankly, I have been involved in legislative actions in the past based on a lot thinner data than that. I think it is more than——

Chairman **Stark**. Would you shudder?

Mr. **Bromberg**. I would say we have used inadequate data since the beginning of the program, which is good because we have said rough justice and rough data is better than the old system. I have a different description than your teeter-totter. It is Robin Hood. I still think we have got to take care of the issue even though I know where it has got to come from.

I think you have got adequate data, yes. I think a severity index in the future would be more accurate.

Chairman. **Stark**. Mr. Bentley?

Mr. **Bentley**. I would agree with what Mike has said. I think the importance is to get started on a path of trying to make the adjustment and then exercising oversight. If we have missed it on the high side or low side, you have the opportunity on a regular basis to come back as more data are available. But to say absent perfect data, we shouldn't do anything. We wouldn't be here testifying on prospective payment. We would be 10 years away from it if we waited for that.

Chairman **Stark**. Let me go, Dr. Mongan, to the transition.

My reluctance to just accept the freeze legislation that has been proposed is not because of my parochial interests obviously. But I am concerned, having experienced freezes before that they never end. They are like HCFA reports. They never arrive.

I think there is enough interest on both sides of the issue of 50-50 to keep everybody at the table long enough to get a satisfactory compromise. Would that fit in with what you are suggesting, if we freeze? Could we wrap up in that legislation, make the changes that you think are necessary? We might not make all those changes to the extent you wish them. But is there any reason why we shouldn't wrap that all up at once.

Dr. **Mongan**. If what you are suggesting is a piece of legislation that, say, includes as Part A a freeze for 12 months, 18 months or something, and as Part B, a provision to deal with disproportionate share hospitals, I am prepared to deal with that.

Chairman **Stark**. But my feeling is that we would never put together Part B if there are now the votes sitting out in the world for the freeze. If there are the votes for the freeze, it is going to be 50-50 from now on.

On the other hand, if people are unsure and haven't made the count, maybe we can get together and work out changes to the system, which I gather a lot of people think are needed. We may not agree on which changes should be made, but I am hearing a lot of people saying we need a lot of change.

Nobody is saying 50-50 is the perfect answer forever—all three witnesses are nodding, affirmative, I assume. Then my feeling would be we ought to go ahead and get to the end result, using whatever transition we have, whether it is a year, three months' freeze, whatever.

I hope you agree. I hope you will help us work on what that end result ought to be.

Dr. **Mongan**. I have testified in favor of a freeze as a transition to get us to where the problems are fixed. At the risk of being a skunk at a garden party fouling this up, I would go on to add personally that I am still not sure I see the magic in this mystical national rate. I don't see anything necessarily wrong with 50-50.

It is crucially important to me to understand that what is important is the prospectivity, not whether the specific rate is X, Y or Z. I am for prospective payment strongly. I am not for cost reimbursement.

I don't know if there is a magic to the national rate as opposed to 50-50, but I am comfortable with the freeze being a transitional step.

Chairman **Stark**. Mike, with regard to return and equity, I have no real quarrel with that. If you would be willing with me to define equity as paid in capital, would you accept that as the only thing you get return on equity; do you want that compromise?

Mr. **Bromberg**. Since you changed the law on a stepped-up basis, that is the only thing we get it on, investor capital.

Chairman **Stark**. Everything else being equal, don't you just transfer appreciation to equity if you are not paying money out, in a static situation? As you pay for the asset, it goes into the equity column; right?

Mr. **Bromberg**. I believe that is correct.

Chairman **Stark**. In a profit hospital, therefore, as you depreciate that asset, whether you pay all cash for it or whether you borrow, you are getting an increasing return at a guaranteed 12 percent; whereas, the nonprofit depreciate that asset and don't add any return for the same asset. That gives you actually an advantage, because if you took the same two curves, it is a return on just an asset, such as an X-ray machine. In the profit operation that curve goes up higher and faster than the nonprofit, because we are building in that 12 percent on the margin increase in equity. That is the only quarrel I have.

Then I think, other than that, you ought to receive the same rate of return for the same machine. I think we both agree to that.

Mr. **Bromberg**. Yes.

Let me say, before I answer, because I want to be able to study it further, that I have to take exception with one comment. That is the advantage. I can read you a list——

Chairman **Stark**. Well, more money, which in my book is an advantage.

Mr. **Bromberg**. Even I understand that. But let me just give you two or three examples of why it is hard to pick one capital-related issue out of context and say there is an advantage.

The rate of return on equity, I am not even sure of the number, but we think it is in the $200 million range now that you have cut it by a third; two years ago, you did.

Just let me give you two or three others. The right to receive philanthrophy that is tax deductible to the giver, in the last year we have available—two years ago—it is $1 million. The right to receive lower interest payments because the tax-exempt bond financing was worth $400 million; the right to pay no taxes as a tax-exempt organization, if it had been taxed as a profit organization, was worth $2 billion.

When you stack those up against return on equity and ask yourself if we have such a competitive advantage, why have not a lot of nonprofits converted to for-profit status? And I find more have gone the other way. I simply say when you put it in perspective, you have to look at (a) all capital issues together. Interest and equity are the same. If you want to abolish one, you have to abolish the other, to be consistent. And we are willing to talk about doing it in a phased-in way under a prospective capital——

Chairman **Stark**. You have the option to go nonprofit any time you want.

Mr. **Bromberg**. That is correct; and vice versa.

Chairman **Stark**. That is right.

So it is not the issue.

Mr. **Bromberg**. And the public benefits from having both of us.

Chairman **Stark**. I know of no other industry where the Government guarantees a return on equity, not even General Electric and General Dynamics.

Mr. **Bromberg**. Look at public utilities. You would find that rates of utilities are two and three times as much.

Chairman **Stark**. The Federal Government doesn't touch it. We have nothing to say about the rate of return on utilities. That is entirely a State issue.

Mr. **Bromberg**. That is the same reason——

Chairman **Stark**. If you guys want to have your rates set by the States, I am sure we can fix that up, too.

Mr. **Bromberg**. We are having enough trouble with the Federal Government. We will look at that investor issue, though.

Chairman **Stark**. That is really the only part that I see that we shouldn't be paying for. You could do nothing, have the machine sit there, not have one patient use it, and the rate of return on this as it builds—you have to pay off the loan, of course—but that doesn't seem critical to me.

Mr. **Bromberg**. We will take a close look at that and get back to you.

Chairman **Stark**. Thank you.

Mr. Rangel.

Mr. **Rangel**. Dr. Bentley, these teaching hospitals provide for hospitals located in poor communities. Do they have contracts with the hospitals? That is, the school would have a contract for services?

Mr. **Bentley**. It depends on where you are in the country, sir. In the city that you come from, most of the medical staff, house staff and supervising physicians, as I understand, are obtained under contract with the affiliated teaching hospitals because the city found 15 to 18 years ago that that was the way it could best staff its hospitals. When you go to the rest of the country, there are a broad variety of arrangements between hospitals and medical schools, both on the extent to which the school provided that function and on the extent to which that function is supported through patient care payments.

For instance, if you go out to a Midwestern State school where the faculty salary is paid totally by State-appropriated funds, that salary may not be put in the Medicare cost report in that State. So there are some differences in terms of how the accounting treatment is done. There are also some differences in the arrangements between the school and either a public or private hospital.

Mr. **Rangel**. But where you would have a contract between the local government and the teaching school, you would not only get city funds for that, or local government funds, but you would also be able to share in Medicare reimbursement for these students' training?

Mr. **Bentley**. In New York City, for example, where the Health and Hospital Corp. would have a contract with a medical school or private hospital to provide staff——

Mr. **Rangel**. Right.

Mr. **Bentley** [continuing]. The cost of the hospital having that contract is included in its Medicare cost report, and the medical education portion of that cost is reported to Medicare, and Medicare pays its share. So, if you will, if you take the hospital in New York—take Bellevue. Bellevue's costs, which include a contract cost, as I understand, with New York University, will be incorporated under Medicare cost reports. The portion for medical education will be included in the Medicare cost report, and on that portion Medicare will pay its share of reimbursing the city for those expenses.

Mr. RANGEL. Well, when you have those types of agreements, do you assign the foreign doctors or those that are not American doctors to the public hospital system? Do you have a way of doing that?

I know a number of hospitals—one of my larger public hospitals, affiliated with Columbia Presbyterian, when you were talking to the chairman about the reimbursement, you have to work out something for now and in the future, you know. In most of our public hospitals we have a large number of Indian and other types of doctors rather than American students.

Mr. BENTLEY. I would have to honestly say I would hope that no one is assigning residents from an integrated joint pool has assigned them on the basis of nationality to any kind of hospital—public, private, urban, suburban.

Mr. RANGEL. I am advocating that that be done. But——

Mr. BENTLEY. I hope they wouldn't do that.

Mr. RANGEL. I hope they would, because we are getting more than our share of foreign doctors.

Mr. BENTLEY. There clearly is a problem in New York City, New Jersey and Connecticut, Detroit and Chicago—particularly where institutions, public or private, are in low-income neighborhoods and have their own residency training programs. Those programs have been less attractive to American citizens, and they have relied——

Mr. RANGEL. To American doctors?

Mr. BENTLEY. Yes.

They have relied to a larger degree on physicians who trained abroad.

Mr. RANGEL. So they would not come under this contract that you are talking about? They would not be coming to these hospitals from the teaching institutions themselves?

Mr. BENTLEY. I would have to investigate that to give you an honest answer.

Mr. RANGEL. If I tell you that these hospitals have a contract with the teaching school, Columbia, they would not be allowed to go out and get foreign doctors, would they?

Mr. BENTLEY. Yes, they can, depending on the arrangement. If the contract with Columbia is solely to provide physicians for supervision and the hospital agrees it will recruit its own residents, then you essentially have two points of decision with the hospital getting the best mix of residents it can, foreign or American, and with Columbia providing the supervising faculty.

I would simply have to look into that and get back to you as to what the arrangement is in any particular setting.

[The following was subsequently received:]

association of american medical colleges

May 22, 1985

Representative Charles B. Rangel
2330 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Rangel:

At the May 14 hearing of the Subcommittee on Health, you questioned me about the distribution of foreign medical graduates in university and municipal hospitals and student participation in the National Health Service Corps.

I have examined three pairs of hospital on the foreign medical graduate topic:

NYY Medical Center - Bellevue
Presbyterian - Harlem
SUNY Downstate - Kings County.

Attachment 1 shows the number of total residents, foreign medical graduate residents, and percentage of foreign trained residents for each hospital reported to the AAMC. Clearly the situation at Presbyterian and Harlem is different from the situation at NYU/Bellevue or SUNY/Kings County. A review of the appropriate pages from the National Residency Matching Program Directory, attachment 2, shows a major difference in residency recruiting practices. NYU (page 59) has a single program recruiting residents for both hospitals so that no separate listing is shown for Bellevue. SUNY (p. 60) has a single program recruiting for both hospitals. On the other hand, Harlem Hospital (p. 57) and Presbyterian (p. 59) recruit separately. I must conclude that this separate recruiting has resulted in the difference in the foreign medical graduates at Harlem and Presbyterian. I would note that a single recruiting program does not necessarily result in a low percentage at both hospitals. NYU/Bellevue have a low percentage of FMGs in either hospital while SUNY/Kings have a high percentage.

I hope this information is helpful to you. If I can be of further assistance to you or your staff please call me at 828-0493. I will write you on the National Health Service Corps. in a few days when I have more information.

Sincerely,

Jim Bentley

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals

JDB/mrl

Attachments

Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

Attachment 1

Residency Program Data in University and Municipal Hospitals

Hospital	Total Residents	Foreign-Trained Residents	Percent FMG's
NYU	168	15	9%
Bellevue	394	45	11
Presbyterian	391	34	9%
Harlem	278	148	53
SUNY Downstate	88	47	54%
Kings County	480	232	48

Source: 1985 COTH Directory

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                                                  QUOTA
NEW YORK CITY & VICINITY

BOOTH MEMORIAL MEDICAL CTR.        (CONT)
        INTERNAL MEDICINE C              182216    18

BRONX LEBANON HOSPITAL CTR
   1276 FULTON AVENUE
   BRONX                 NY 10456
   TEL:212-588-7000 EXT:804
      ASSOC: Y 1  EINSTEIN (YESHIVA)
        INTERNAL MEDICINE C              147116    17
        OBSTETRICS-GYNECOLOGY C          147123     2
        PEDIATRICS C                     147128     9
        PSYCHIATRY C                     147141     3
        GENERAL SURGERY C                147119     4

BRONX MUNICIPAL HOSPITAL CTR
   STAFF HOUSE ROOM 103
   PELHAM PKWY & EASTCHESTER RD
   BRONX                 NY 10461
   TEL:212-430-8801
      ASSOC: Y 1  EINSTEIN (YESHIVA)
        ANESTHESIOLOGY C                 183131     1
        MEDICINE-PRELIMINARY P           183115     4
        INTERNAL MEDICINE C              183116    22
        MEDICINE-PRIMARY C               183117     4
        OBSTETRICS-GYNECOLOGY C          183123     6
        PATHOLOGY C                      183128     4
        PSYCHIATRY C                     183141    12

BROOKDALE HOSPITAL MED CNTR
   LINDEN BOULEVARD AND
   ROCKAWAY PARKWAY
   BROOKLYN NEW YORK   NY 11212
   TEL:212-240-5722
      ASSOC: Y 1  SUNY, N.Y.C
              Z 2  NEW YORK UNIVERSITY
        FAMILY PRACTICE C                141920     8
        MEDICINE-PRELIMINARY P           141915    11
        INTERNAL MEDICINE C              141916    15
        MEDICINE-PEDIATRICS C            141930     2
        OBSTETRICS-GYNECOLOGY C          141923     4
        PEDIATRICS C                     141928    12
        PSYCHIATRY C                     141941     5
        SURGERY-PRELIMINARY P            141918     4
        GENERAL SURGERY C                141919     4

BROOKLYN HOSPITAL-CALEDONIAN
   121 DEKALB AVENUE
   BROOKLYN              NY 11201
      ASSOC: Y 1  SUNY, N.Y.C
        INTERNAL MEDICINE C              142016     9
        PEDIATRICS C                     142028     3
        GENERAL SURGERY C                142019     5

CABRINI MEDICAL CENTER
   ROOM 102
   227 EAST NINETEENTH STREET
   NEW YORK              NY 10003
   TEL:212-725-6000 EXT: 6629
      ASSOC: Y 1  NEW YORK MEDICAL
        MEDICINE-PRELIMINARY P           147215     8
        INTERNAL MEDICINE C              147216    10
        SURGERY-PRELIMINARY P            147218    11
        GENERAL SURGERY C                147219    11

CATHOLIC MEDICAL CENTER
   88-25 153 STREET
   JAMAICA               NY 11432
   TEL:212-657-6800 EXT:4115
      ASSOC: Z 2  SUNY, N.Y.C
             Y 2  CORNELL
        FAMILY PRACTICE C                148020     2
        INTERNAL MEDICINE C              148016    18
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NEW YORK CITY & VICINITY

CATHOLIC MEDICAL CENTER            (CONT)
        OBSTETRICS-GYNECOLOGY C          148023     3

CONEY ISLAND HOSPITAL
   2601 OCEAN PARKWAY
   BROOKLYN              NY 11235
      ASSOC: Z 1  SUNY, N.Y.C
        INTERNAL MEDICINE C              142216     8

CREEDMOOR PSYCHIATRIC CENTER
   ROOM 218 JACK DUFFY REHABCTR
   80-45 WINCHESTER BOULEVARD
   QUEENS VILLAGE        NY 11427
   TEL:212-464-7500 EXT:5131
      ASSOC: NO ASSOCIATIONS
        PSYCHIATRY S                     288061     3

FLUSHING HOSP. & MED. CENTER
   4500 PARSONS BLVD.
   FLUSHING              NY 11355
   TEL:212-670-5000 EXT:5804
      ASSOC: Y 2  EINSTEIN (YESHIVA)
             Z 2  SUNY, N.Y.C
        INTERNAL MEDICINE C              144516    12
        OBSTETRICS-GYNECOLOGY C          144523     2
        PEDIATRICS C                     144528     5
        GENERAL SURGERY C                144519    10

HARLEM HOSPITAL CENTER
   KING PAVILION 14104
   506 LENOX AVENUE
   NEW YORK              NY 10037
   TEL:212-491-8202
      ASSOC: Y 1  COLUMBIA P & S
        MEDICINE-PRELIMINARY P           147815     8
        INTERNAL MEDICINE C              147816    25
        OBSTETRICS-GYNECOLOGY C          147823     4
        PEDIATRICS C                     147828     9
        PSYCHIATRY C                     147841     4
        GENERAL SURGERY C                147819     6
        TRANSITIONAL P                   147814     5

INTERFAITH MEDICAL CENTER
   555 PROSPECT PLACE
   BROOKLYN              NY 11238
      ASSOC: Y 1  SUNY, N.Y.C
        INTERNAL MEDICINE C              142816    24
        OBSTETRICS-GYNECOLOGY C          142823     5
        PEDIATRICS C                     142828     1

THE JAMAICA HOSPITAL
   89 AVENUE & VAN WYCK EXPWY
   JAMAICA               NY 11418
   TEL:212-657-1800 EXT:1810
      ASSOC: Z 2  CORNELL
             Z 2  SUNY, N.Y.C
        FAMILY PRACTICE C                144920     3
        INTERNAL MEDICINE C              144916    10
        OBSTETRICS-GYNECOLOGY C          144923     2

JOINT DISEASES NORTH GENERAL
   1919 MADISON AVENUE
   NEW YORK              NY 10035
      ASSOC: Y 2  MOUNT SINAI, N.Y.C
        INTERNAL MEDICINE C              147916     6
        GENERAL SURGERY C                147919     5
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NEW YORK CITY & VICINITY

MT SINAI SCH MED AFFL HOSPS         (CONT)
          PEDIATRICS C                    149128      7

THE MOUNT SINAI HOSPITAL
   1 GUSTAVE LEVY PLACE
   NEW YORK               NY 10029
      ASSOC: Y 1  MOUNT SINAI, N.Y.C
          ANESTHESIOLOGY C                149031      2
          MEDICINE-PRELIMINARY P          149015      4
          INTERNAL MEDICINE C             149016     28
          NEUROLOGY C                     149035      2
          OBSTETRICS-GYNECOLOGY C         149023      8
          PATHOLOGY C                     149025      6
          PEDIATRICS C                    149028     10
          PSYCHIATRY C                    149041      6
          PSYCHIATRY C-PEDIATRICS         149046      3
          PSYCHIATRY C-MEDICINE           149082      2
          SURGERY-PRELIMINARY P           149018     25
          GENERAL SURGERY C               149019      7

THE NEW YORK HOSPITAL
   F104
   525 EAST 68TH STREET
   NEW YORK               NY 10021
   TEL:212-472-5323
      ASSOC: Y 1  CORNELL
          ANESTHESIOLOGY C                148231      7
          MEDICINE-PRELIMINARY P          148215      6
          INTERNAL MEDICINE C             148216     31
          OBSTETRICS-GYNECOLOGY C         148223      8
          PATHOLOGY C                     148225      5
        + PEDIATRICS C                    148228     13
          PSYCHIATRY C                    148241      8
          GENERAL SURGERY C               148219     15

NEW YORK INFIRMARY-BEEKMAN
   170 WILLIAM ST
   NEW YORK               NY 10038
   TEL:212-233-5300 EXT:421
      ASSOC: Z 1  NEW YORK UNIVERSITY
          MEDICINE-PRELIMINARY P          187515      6
          INTERNAL MEDICINE C             187516     14
          OBSTETRICS-GYNECOLOGY C         187523      3
          GENERAL SURGERY C               187519      4

NEW YORK MEDICAL COLLEGE
   METROPOLITAN HOSP CENTER
   1901 FIRST AVENUE
   NEW YORK               NY 10029
   TEL:212-360-6271
      ASSOC: Y 1  NEW YORK MEDICAL
          EMERGENCY MEDICINE C            147333      3
          MEDICINE-PRELIMINARY P          147315      4
          INTERNAL MEDICINE C             147316     13
          MEDICINE-PEDIATRICS C           147330      4
          OBSTETRICS-GYNECOLOGY C         147323      8
          ORTHOPEDIC SURGERY C            147338      3
          PEDIATRICS C                    147328     18
          PHYS MEDICINE & REHAB C         147340      2
          PSYCHIATRY C                    147341      5
          SURGERY-PRELIMINARY P           147318      0 R
          GENERAL SURGERY C               147319     10
          UROLOGY C                       147344      2

NEW YORK VA-NYU PROGRAM
   408 FIRST AVENUE
   NEW YORK               NY 10010
   TEL:212-686-7500 EXT:456
      ASSOC: Y 1  NEW YORK UNIVERSITY
          MEDICINE-PRELIMINARY P          148615      4
          INTERNAL MEDICINE C             148616     10
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NORTH SHORE UNIVERSITY HOSP
   300 COMMUNITY DRIVE
   MANHASSET              NY 11021
   TEL:516-562-0100
      ASSOC: Y 1  CORNELL
          MEDICINE-PRELIMINARY P          148715      4
          INTERNAL MEDICINE C             148716     25
          OBSTETRICS-GYNECOLOGY C         148723      3
          PATHOLOGY C                     148725      2
          PEDIATRICS C                    148728     12
          PSYCHIATRY C                    148741      4
          GENERAL SURGERY C               148719     12

NYU MEDICAL CENTER
   N-10-5 DEANS OFFICE
   550 FIRST AVENUE
   NEW YORK               NY 10016
   TEL:212-340-5506
      ASSOC: X 1  NEW YORK UNIVERSITY
          ANESTHESIOLOGY C                297631      3
          MEDICINE-PRELIMINARY P          297615      4
          INTERNAL MEDICINE C             297616     22
          MEDICINE-PRIMARY C              297617      4
          OBSTETRICS-GYNECOLOGY C         297623      6
          ORTHOPEDIC SURGERY C            297638      6
          PATHOLOGY C                     297625      4
          PEDIATRICS C                    297628     10
          PEDIATRICS-PRIMARY C            297629      4
          PHYS MEDICINE & REHAB C         297640      4
          PSYCHIATRY C                    297641     15
          SURGERY-PRELIMINARY P           297618     14 R
          GENERAL SURGERY C               297619     10

PRESBYTERIAN HOSPITAL
   BOX 382
   622 WEST 168 STREET
   NEW YORK               NY 10032
   TEL:212-694-2832
      ASSOC: Y 1  COLUMBIA P & S
          INTERNAL MEDICINE C             149516     30
          OBSTETRICS-GYNECOLOGY C         149522      5
          PATHOLOGY C                     149525      4
          PEDIATRICS C                    149528     18
          SURGERY-PRELIMINARY P           149518     11
          GENERAL SURGERY C               149519      6

ST BARNABAS HOSP
   DEPT OF MEDICAL ED
   183 ST AND THIRD AVE
   BRONX                  NY 10457
   TEL:212-960-6214
      ASSOC: Y 2  CORNELL
          MEDICINE-PRELIMINARY P          311315      4
        + INTERNAL MEDICINE C             311316     12

ST LUKES-ROOSEVELT HOSP CTR
   AMSTERDAM AVE AT 114TH ST
   NEW YORK               NY 10025
   TEL:212-870-1911
      ASSOC: Y 1  COLUMBIA P & S
          PEDIATRICS C                    107028     10
          RADIOLOGY - DIAGNOSTIC C        107042      5

ST LUKES-ROOSEVELT HOSP CTR
   ROOSEVELT HOSPITAL
   428 WEST 59TH STREET
   NEW YORK               NY 10019
   TEL:212-870-1911
      ASSOC: Y 1  COLUMBIA P & S
          MEDICINE-PRELIMINARY P          148815      6
          INTERNAL MEDICINE C             148816     12
          PATHOLOGY C                     148825      1
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ST LUKES-ROOSEVELT HOSP CTR (CONT)
PSYCHIATRY C 149841 4
GENERAL SURGERY C 149819 11

ST LUKES-ROOSEVELT HOSP CTR
ST LUKES HOSPITAL
AMSTERDAM AVE AT 114TH ST
NEW YORK NY 10025
TEL:212-870-1911
ASSOC: Y 1 COLUMBIA P & S
MEDICINE-PRELIMINARY P 149815 6
INTERNAL MEDICINE C 149816 15
OBSTETRICS-GYNECOLOGY C 149823 6
PSYCHIATRY C 149841 3
GENERAL SURGERY C 149819 11

ST. VINCENT'S HOSPITAL
153 WEST 11TH STREET
NEW YORK NY 10011
TEL:212-790-7512
ASSOC: Y 1 NEW YORK MEDICAL
INTERNAL MEDICINE C 150016 12
OBSTETRICS-GYNECOLOGY C 150023 2
PEDIATRICS C 150028 6
PSYCHIATRY C 150041 5
GENERAL SURGERY C 150019 14
TRANSITIONAL P 150014 18

ST VINCENTS MEDICAL CENTER
355 BARD AVENUE
STATEN ISLAND NY 10310
TEL:212-390-1181
ASSOC: Y 1 NEW YORK MEDICAL
INTERNAL MEDICINE C 151416 10
OBSTETRICS-GYNECOLOGY C 151423 2
PEDIATRICS C 151428 4
RADIOLOGY - DIAGNOSTIC C 151442 2

THE STATEN ISLAND HOSPITAL
ADMINISTRATION
475 SEAVIEW AVE.
STATEN ISLAND NY 10305
TEL:212-390-9906
ASSOC: Y 1 SUNY, N.Y.C
MEDICINE-PRELIMINARY P 151515 9
INTERNAL MEDICINE C 151516 13
OBSTETRICS-GYNECOLOGY C 151523 1
PEDIATRICS C 151528 5
SURGERY-PRELIMINARY P 151518 4
GENERAL SURGERY C 151519 2

STATE UNIV -KINGS COUNTY HOS
BLD. D ROOM 118
451 CLARKSON AVENUE
BROOKLYN NY 11203
TEL:212-735-2676
ASSOC: X 1 SUNY, N.Y.C
ANESTHESIOLOGY C 142831 10
FAMILY PRACTICE C 142820 4
INTERNAL MEDICINE C 142016 45
OBSTETRICS-GYNECOLOGY C 142823 8
ORTHOPEDIC SURGERY C 142838 6
PATHOLOGY C 142825 2
PEDIATRICS C 142828 16
PSYCHIATRY C 142841 8
SURGERY-PRELIMINARY P 142818 8
GENERAL SURGERY C 142819 13

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NEW YORK CITY & VICINITY

BRONX VA MEDICAL CENTER
130 WEST KINGSBRIDGE ROAD
BRONX NY 10468
TEL:212-584-9000 EXT:1733
ASSOC: Y 1 MOUNT SINAI, N.Y.C
INTERNAL MEDICINE C 282716 8

WOODHULL MED CTR
ROOM 8829
760 BROADWAY
BROOKLYN NY 11206
TEL:212-963-8806
ASSOC: Y 2 SUNY, N.Y.C
INTERNAL MEDICINE C 311616 24

NEW YORK STATE

NIAGARA FALLS MEM. MED. CTR.
FAMILY PRACTICE CENTER
501 TENTH STREET
NIAGARA FALLS NY 14301
TEL:716-278-4818
ASSOC: Y 3 SUNY BUFFALO
FAMILY PRACTICE C 183820 4

SO NASSAU COMMUNITIES HOSP
2445 OCEANSIDE RD
OCEANSIDE NY 11572
TEL:516-763-3909
ASSOC: Y 1 SUNY, STONY BROOK
FAMILY PRACTICE C 308720 5

BROOKHAVEN MEMORIAL HOSPITAL
101 HOSPITAL ROAD
PATCHOGUE NY 11772
TEL:516-654-7786
ASSOC: Y 1 SUNY, STONY BROOK
FAMILY PRACTICE C 304420 8

HIGHLAND HOSPITAL-ROCHESTER
SOUTH AVE AT BELLEVUE DR
ROCHESTER NY 14620
TEL:716-473-2200
ASSOC: Y 1 ROCHESTER
FAMILY PRACTICE C 180820 12
MEDICINE-PRELIMINARY P 180815 2
INTERNAL MEDICINE C 180816 6

ROCHESTER GENERAL HOSPITAL
1425 PORTLAND AVENUE
ROCHESTER NY 14621
TEL:716-338-4148
ASSOC: Y 1 ROCHESTER
MEDICINE-PRELIMINARY P 180915 4
INTERNAL MEDICINE C 180916 11
OBSTETRICS-GYNECOLOGY C 180923 3

ST MARYS HOSPITAL
89 GENESEE STREET
ROCHESTER NY 14611
TEL:716-464-3250
ASSOC: Y 1 ROCHESTER
INTERNAL MEDICINE C 151016 7

STRONG MEMORIAL HOSPITAL
BOX 612
601 ELMWOOD AVENUE
ROCHESTER NY 14642
TEL:716-275-4807
ASSOC: Y 1 ROCHESTER
ANESTHESIOLOGY C 151121 3
INTERNAL MEDICINE C 151116 16

Mr. **Rangel**. I would appreciate if you did that, because, Dr. Mongan, you may have been here when Dr. Davis was saying that if there are differences in the cost of taking care of the poor, that it could be just a question of inefficiency. I would want you to comment on that. But if we have all these teaching hospitals involved in providing services to the poor—that is, contracts—then it would seem to me that these teaching institutions ought to be testifying, too, as it relates to efficiency. Whether we are dealing with American or foreign doctors, they should be testifying.

Dr. **Mongan**. I would like the opportunity to respond to the efficiency argument. I know of no data that will show public hospitals are less efficient than the nonpublic hospitals. In fact, there is quite a body of data to the contrary. In other words, because we have been (a) starved for funds, and (b) for over a decade on locally budgeted prospective payment, we have been forced to become and remain more efficient in order to get help from local government.

There are a number of statistics that show ours are the only institutions over the past few years that are seeing an increase of occupancy. My institution testified here a month ago. We are up 12 percent in inpatient days over the past 2 years, and we cut our staff by 7.4 percent in the same period of time.

There are few hospitals in the United States that can come in with those numbers. So I don't think efficiency speaks to it. In fact, we have put together another chart which indicates very clearly, I think, that there are real reasons why the costs are higher, and they don't relate to efficiency. They relate to four categories of things.

First, we do treat sicker patients in our facilities. Dr. Davis again found she couldn't find differences in severity. I submit she is not looking very hard, and she can come out and interview any nurse who worked in more than one hospital in Kansas, or physician, and there is data that our patients are sicker and require more care, particularly in terms of multiple complications. We simply don't get a lady coming in from the suburbs who needs her gall bladder out. We get a lady from a nursing home who has bed sores, kidney disease and also needs her gall bladder out. That is an expensive case. We get a heart attack victim from the street with frostbite, alcoholism and other sorts of conditions we have to deal with.

In addition, we have the discharge problems indicated. We have patients who don't have a place to go. They don't have families around to take care of them and give them the post-hospital treatment they need. That adds to our costs.

We have extra services we have to provide. It takes a larger staff of social service workers to deal with the patients we have. It takes a larger security force because of the locations we are in, a variety of extra services, and higher standby costs. We are running poison control units, trauma centers, and high volume ambulatory centers, because there are no other doctors in the lowest income area?

Those are solid, substantial reasons for higher costs in public hospitals, and frankly I think it is insulting for HCFA to say it is because we are less efficient when they have no data to make that claim, and we have plenty of data on the other side.

Mr. **Rangel**. Mr. Bromberg, in your association, does it come across your desk, the assignment of doctors based on citizenship at all, or do you find an even mix?

Mr. **Bromberg**. We have gotten very little mail or questioning or complaints about it, so I have to honestly say no, the issue doesn't come up.

Mr. **Rangel**. Public hospitals are a part of your overall——

Mr. **Bromberg**. No. We have purchased—our member companies have brought about 35 or 40 public hospitals, but they are the kind mostly in the South, and is probably because we have so few members in New York City where this is a problem. It has not crossed our desk, no.

Mr. **Rangel**. Dr. Bentley, I want to join with the Chairman in seeing whether we can find a comprehensive way to broaden the support for medical students. Is there any way that you might suggest as to whether or not they would be involved in any public service after they graduate, finished their internship?

Mr. **Bentley**. I would note there has been a program of the National Health Service Corps to both help students gain training and to require a public service portion or at least an assignment in underserved medical areas, and it is my understanding that that program has been, if not eliminated, at least has been substantially reduced in funding.

Mr. **Rangel**. Was that the program that doctors could buy out of?

Mr. **Bentley**. There was an option that physicians could buy out of it. I am not the person who could give you that data. That is not in the area where I work. I am really not knowledgeable about how much——

Mr. **Rangel**. Can you check on that and see how many doctors bought out of it? The whole idea is not to embarrass anybody but rather to find out if we are going to help the physicians. We should be able to expect that they make some contribution in areas that don't have the political clout that some of the teaching universities have.

Mr. **Bentley**. Understood.

Mr. **Rangel**. Thank you.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Thank you, Mr. Chairman.

Sometimes when we are just talking about the central systems transfer payment from a trust fund, we lose sight of all the other medical care that has to get delivered that isn't paid for by taxpayers' dollars. It would seem to me that we have to then be careful when we talk about disproportionate share that maybe there is another definition of that. Maybe it is that we are trying to load up the system and pay for care through Treasury or payroll tax, because you can get it from 435 politicians in the House as opposed to having to go out to 50 States and get the rates set by 50 States.

It is like seatbelts or airbags or drinking legislation. It seems to be easier to get it from the Congress, because it is a one-step shopping trip, than having to go to 50 places like you do for water rates, telephone rates, et cetera.

So I guess I worry about whether we forget about the private sector's responsibility, whether we worry about the insurance industry's responsibility to cover this. And if we load up the public sector's reimbursement, we may be just raising the costs for everybody else.

I guess I worry about medical costs to nongovernment reimbursed costs of care while we talk about these things. And I don't know that that is meant to elicit any comment from you except that I worry a little if you are riding just one horse, because it is easier to get the money here than somewhere else.

Dr. **MONGAN**. Could I comment?

Mr. **DAUB**. Sure. Don't feel it was aimed at you.

Dr. **MONGAN**. Well, there are two points I would like to make in response to that. First, I want to clearly make the point, if I didn't in my testimony—and I think Mike did make it near the end of his—what we are asking for in the disproportionate fair adjustment is not for Federal Government help in dealing with all those people who don't have coverage.

I would love to come back and talk about that subject some time. And I think Congress has a responsibility to address that subject some time.

But what we are talking about here are simply the higher costs of the Medicare patients we serve; in other words, those patients who have been assumed as a Federal responsibility. We are not moving any other burden on the Federal Government; just asking the Federal Government to bear its fair share of the Medicare costs rather than pass them on to our other payors, and they happen to be State and local government.

I guess that leads me to the second point. The public hospitals have a long tradition of being dependent on the local government for their basic support, and that local government has been a pretty sound partner throughout that period of time. Our financing profile is quite typical of other public facilities. We get 33 percent of our money from the city and county. We do go to them. They are supportive of what we do. They make sure we are holding costs down.

We are addressing all payors, not just dealing with the 435 politicians in Congress. We are dealing with the State and local people, too. We are just asking for a focus on that share that is the Medicare issue.

Mr. **DAUB**. Anyone else?

Mr. **BROMBERG**. I would just like to add that we are also viewing this disproportionate share as a limited important way to judge whether there are higher Medicare costs for certain hospitals. But on the bigger issue, it is like the teeter-totter again, or Robin Hood theory. We have a lot of States and counties not living up to their responsibility on the bigger question of this care, and that is why Washington, D.C. will be asked more to get involved.

There are two sides to that story. You have States in this country with Medicaid levels of eligibility that are embarrassingly low and others that are very high, and the ones who are low have indigent care problems. They don't want to pay for it. Just like there are people here who don't want to pay for certain things, so they look elsewhere to get it. But it is the Government's responsibility at some level.

Second, there are times when the States and counties can't handle it, such as a couple years ago when Detroit had huge unemployment. Could you really expect Michigan alone to solve that problem, or was there a Federal role? It was debated and dropped, and they never made it. But I think the day will come when the Congress will have to face this issue, at least in part, and admit there is a national responsibility to help people get health care, just as you face it for housing and food.

You have public housing, federally funded. You have food stamps, federally funded. And the one obvious omission for some reason is health care, and until now the reason has been you have told us to raise up our prices and have a hidden cross-subsidy and get it that way, or else let the States and cities worry about funding these hospitals. We can't do that any more in this price-competitive environment.

Mr. **Daub**. I think both your answers are appropriate. And I agree; I think it is more complicated, but we are focusing on a special area.

There is a broader issue. I think you have elaborated on it for the record, and I think it is important.

What would your price tag be to address the disproportionate share problem, anybody want to guess? How many Federal dollars are we talking about from the trust fund?

Dr. **Mongan**. My understanding is there are numbers in the range of $250 million would be a sum that would——

Mr. **Daub**. $250 million would jiggle it around enough to cover it? Not a billion?

Dr. **Mongan**. Not a billion, is my understanding.

Mr. **Bentley**. In the narrow sense we were talking about, the disproportionate cost of Medicare patients, not the larger issue of indigent care more generically.

Mr. **Daub**. I appreciate that, too.

I do appreciate, Mike, your indication of support for this wage index adjustment.

Do you agree that the hospitals that have been overpaid due to overstated wage indexes will support the revised wage index as a more fair one as long as the retroactive provision is removed?

Maybe you would all like to comment.

Mr. **Bromberg**. I would like to say I believe we will. As long as it is prospective and the way you want to do it, we will.

I would like to add that it is another example of how you can isolate one issue like the transition, because this wage index has a tremendous bearing on who the supposed or alleged winners and losers are under the transition.

Going back to what Chairman Stark said about putting this all together in a package, I think it has to be done that way. You cannot leave out the transition, the wage index, the fair price increase or anything, and come up with a package unless you look at it all together.

Yes, we would support it. And it has impact on the other issues.

Mr. **Daub**. Not so much was I concerned about support or not. But the question of retroactivity has a winner or loser perception, and maybe a freeze without this change will be worse for hospitals. Better get this than nothing?

Mr. **Bromberg**. Depends on where they are located.

Mr. **Daub**. Winners and losers again?

Mr. **Bromberg**. Yes. I have it in my own membership.

The one thing we would all agree on, at least from the precedent, regardless of the money, is retroactivity is a bad precedent. All changes in this law should be prospective. I think this wage index is understood by our members on both sides of the issue that it is better than the one we had before, so let's go with it.

Mr. **Daub**. Anything else?

Mr. **Bentley**. I would concur with Mike's statement. Our board has taken it up. They have said clearly—for not only precedent reasons but policy—it should be prospective. They have tried to stay away from the narrow numbers game and have said instead, let's get the best wage index we can. Certainly, if the current index is not correct, that will hurt some. That will help some.

But the political agreement, as we understand it, is to recognize differences in the cost of doing business. As we are better able to understand and incorporate those differences and have better data, we ought to pick it up.

Dr. **Mongan**. I would agree.

Chairman **Stark**. Mr. Coyne.

Mr. **AuCoin**. I have no questions.

Chairman **Stark**. Mr. Duncan?

Mr. **Duncan**. Thank you, Mr. Chairman.

How much greater is the cost, Dr. Bentley, in a teaching hospital per patient per day, than we find in the private and for-profit hospitals?

Mr. **Bentley**. Mr. Duncan, I am sorry to say I don't have that right on the edge of my mind. If you look at the Medicare data that has been run taking out the direct costs, which average about 6 percent of the teaching hospitals' cost, there is the resident-to-bed adjustment, which includes a lot of factors. And I have seen at least two analyses which suggest that that should be—that an adjustment should vary with the number of residents, and the ratio——

Mr. **Duncan**. What factors do you put into the costs? I have heard you put everything in from the lightbulbs to part of the president's salary and everything else.

Mr. **Bentley**. When we are looking at the so-called pass-through, direct costs—they are the costs of stipends of any trainee—there are costs for the faculty time spent supervising him while not billing a Part B fee for service; there are the overhead operations of the hospital. In that sense, it is a full accounting concept of what it costs to run that program element.

Having already removed those costs using the cost reports they had available, HCFA then looked at the difference in cost between teaching and nonteaching hospitals, adjusting for case mix, the original area wage index, region of the country, bed size, and size of urban area, and they found one set of numbers.

The best data I have seen recently suggests that adjustment should be someplace in the area of roughly 9 percent per one-tenth resident per bed. Then there is a curvilinear transformation of that which I would be glad to explain, but I need a piece of paper and help to do it. I will sit down with a member of your staff and do it, if that is appropriate.

Mr. DUNCAN. Dr. Mongan indicated there wasn't any difference, your services weren't superior or better in your hospitals than in for-profit hopsitals and public hospitals. I saw data recently on the VA which showed in some hospitals it was almost twice the cost of the teaching hospitals for the VA than the private and for-profit hospitals.

I wonder if they are getting superior services? I know in my State a lot of veterans don't want to be sent to the teaching hospitals. They will beg you not to send them. I won't say which one. But we do have that situation. I was just wondering if we would compare the services they get, whether it is worth the extra 9 or 10 percent you are asking for.

Mr. BENTLEY. I think what we have to be careful about is if we compare the average cost of a nonteaching hospital with the average cost of a teaching hospital. If you look at urban area hospitals in Medicare, the average facility is 250 beds, provides a more modest scope of services than the generally over 500 or 600 bed teaching hospital.

So we are not only picking up differences in the teaching program, we are picking up differences in the basic operations of the institution. The two averages differ substantially in total—probably if I had to guess on average about 30 percent or 35 percent.

That is not simply a difference of teaching, it is a difference of teaching, difference of severity of service, scope of service and when you take the larger hospital whether it would be teaching or nonteaching. You take a hospital with a large open heart surgery service, if you spread those costs across all patients it looks as if that hospital is more expensive for all of its patients.

In fact, we have not historically encouraged hospitals to set and identify product line pricing, so it's difficult to compare a routine appendectomy in a teaching, nonteaching, large hospital, or small hospital. It's my belief that that is part of the direction that prospective payment and other initiatives are moving us and across time we will be able to compare them, and you and others will be able to make the judgment of is it worth it?

Mr. DUNCAN. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Any other questions?

I want to thank the panel very much. The staff may have questions that they might submit to you and I hope you would respond for the record in writing.

Thank you very much.

The next panel is Mr. Michael Zimmerman, Associate Director, Human Resources Division, and Mr. Richard P. Kusserow, Inspector General.

Mr. Zimmerman is accompanied by Edwin Stropko, Group Director and Mr. Kusserow is accompanied by Larry Simmons, Director, Health Care Financing Audit Division.

Mr. ZIMMERMAN. Mr. Chairman, Mr. Stropko is in Miami this week to look at the HMO program there, instead I am accompanied by Mr. Iffert on my immediate left and Mr. Ken Brake, Mr. Brake was responsible for the work involving cost reports which is discussed in this statement.

Chairman STARK. Thank you, and welcome to the committee.

Mr. Zimmerman, would you proceed?

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. ZIMMERMAN. Thank you, Mr. Chairman, and members of the committee, we are pleased to be here today to discuss two issues relating to Medicare reimbursement to hospitals.

The first issue I will discuss deals with HCFA's use of unaudited hospital cost reports and in establishing the prospective payment rates. By using unaudited and otherwise incorrect data in calculating payment rates, HCFA has substantially inflated the Medicare payments to hospitals under PPS.

If no adjustments are made to correct this, Medicare could overpay inpatient hospital services by about 4.3 percent or about $940 million in fiscal year 1986.

During the next 3 years these excessive Medicare payments would total over $8 billion.

Chairman STARK. Billion?

Mr. ZIMMERMAN. $8 billion.

Chairman STARK. Over the next how many years?

Mr. ZIMMERMAN. Five years. Attachment I of my statement breaks it out by fiscal years starting with fiscal year 1986. I might add that attachment II includes, the four waiver States and they increase the estimate to $10 billion over 5 years.

Normally these yearly hospital cost reports are desk audited by intermediaries to assess their completeness and accuracy and unallowable costs are dropped. Of the 5,501 hospital cost reports used to develop the rates, only 62—about 1 percent—had been audited at the time the rates were developed.

Since then, HCFA has audited cost reports and has not adjusted PPS rates to reflect audit results. To determine the impact of using unaudited cost reports in establishing the PPS payment rates we took a random sample of 418 field audited cost reports and compared them with the preaudit cost data used by HCFA to compute the payment rates.

We found that as a result of the audits, substantial dollar adjustments were made by the intermediaries to the 1981 cost reports for unallowable costs. Adjustments were made for such unallowable costs as Federal income taxes, Hill-Burton free care costs and directorship fees.

For example, one cost report for a hospital was adjusted by $1.3 million because Federal income taxes, an unallowable cost, were claimed.

HCFA officials said that unaudited data were used because of the short time frame available in which to develop an implement PPS. If audited cost data were used we estimate that the fiscal year 1986 payments to hospitals could be reduced by 3 percent or about $657 million.

Our analysis of the 1981 cost report also show that some capital costs were inappropriately included in the PPS rates. All capital costs should be excluded from the base year cost data because capital is paid for separately as a passthrough.

In extracting data from hospital cost reports, HCFA did not identify cost allocated to the ancillary departments and special care units.

Consequently these capital costs have been erroneously included in the development of the rates and hospitals are being paid twice for them.

We estimate that these unallowable capital costs have increased the PPS payment rates by 1.3 percent. This amounts to $285 million in fiscal year 1986 expenditures. We also found that HCFA made errors in coding and computing the information from base year cost reports and in programming the computations using this data. We believe an adjustment to the standardized amount to compensate for inflated base year costs would be appropriate.

HCFA by using our data as well as other information, could develop an adjustment to base year costs. We would be pleased to work with HCFA to help facilitate the development of such an adjustment.

As a longer term strategy, however, we believe HCFA should recompute the base rate using more current data reflecting hospital's operating experiences under PPS.

The second issue I will briefly discuss relates to Medicare payments to proprietary hospitals for return on equity.

Medicare allows proprietary hospitals a return on equity capital invested and used in providing patient care. As with capital costs, return on equity is treated separately under Medicare's prospective payment system and continues to be passed through for reimbursement.

We have a review underway to assess what happens to hospital costs and services when nonprofit hospitals are purchased by private sector businesses.

In a review of 30 hospitals that have undergone such a change in ownership since 1980, we found the added return on equity claimed by hospitals averaged about $143 per Medicare discharge. The 30 hospitals claimed about $4.3 million annually for return on equity.

The issue as we see it is whether a return allowance should be explicitly provided for by Medicare as under the present system, or whether proprietary hospitals' return should obtain exclusively from their ability to provide services at a profit.

Under PPS, not-for-profit hospitals gain or lose on the basis of whether their costs are lower or higher than the prospective payments because Medicare does not provide them a return on equity allowance.

Eliminating the return on equity allowance would therefore place the proprietary and not-for-profit hospitals on the same footing in terms of Medicare's payment rules.

We believe the question of whether to continue explicitly providing for proprietary hospitals a return on equity allowance is one that merits Congressional attention. PPS is designed to reward efficient hospitals. As with not-for-profit hospitals, proprietary hospitals that cannot provide services at Medicare rates should be expected to economize or absorb their losses.

On the other hand, eliminating the explicit return provisions will, by definition, reduce profitability which may have an impact on the availability of investor capital to the hospital industry.

Both issues should be considered in developing policies on this matter.

Mr. Chairman, that concludes my statement.

[The prepared statement follows:]

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the Committee:

We are pleased to be here today to discuss two issues related to Medicare reimbursement to hospitals:

(1) The impact of the Health Care Financing Administration's (HCFA's) use of unaudited hospital cost reports in establishing the Prospective Payment System (PPS) payment rates.

(2) The Return on Equity payments to proprietary hospitals.

The information presented in this testimony is a composite of information from our past reports and testimony, as well as from our ongoing assignments. The specific scope of our work, as it relates to the two major issues, will be detailed further as we discuss each issue.

PPS PAYMENT RATES ARE OVERSTATED

Using unaudited and otherwise incorrect data in calculating the standardized payment rates has substantially inflated the Medicare reimbursements that are, and will be made to hospitals under PPS. In calculating the national PPS rates, HCFA

--used unaudited hospital cost data to develop the cost per discharge,

--included capital costs that should have been excluded, and

--made coding and computation errors.

If no adjustments are made to the current rates to correct these problems, Medicare could overpay inpatient hospital services by about 4.3 percent, or about $940 million in fiscal year 1986. Based on these preliminary estimates, Medicare overpayments could total over $8 billion during the next 5 years.[1]

The Prospective Payment System

Concerned about growing health care costs, the Congress established a Medicare prospective payment system for hospitals in the Social Security Amendments of 1983 (Public Law 98-21). PPS was designed to cover hospital operating costs for routine, ancillary, and intensive care inpatient services. In contrast to the cost reimbursement system that it replaced, PPS pays a predetermined rate for each hospital discharge, regardless of the number of services provided or the length of the patient's hospital stay.

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[1] These estimates are conservative in that they exclude the four states--Maryland, Massachusetts, New York, and New Jersey--that operate their own hospital reimbursement systems under waivers granted by the Department of Health and Human Services (HHS). Congressional Budget Office (CBO) staff advised us to include these states in our analysis because any reduction in PPS rates would also require a reduction in these states rates since the states' system can be no more costly than PPS. Including the waiver states would increase our estimates presented in this testimony by about $2 billion over 5 years. We summarize how we computed our estimates excluding the waiver states in attachment I and including them in attachment II.

The PPS payment rate is generally calculated based on two key factors. First, HCFA established a weighting factor for each of 468 diagnosis related groups (DRGs)--diagnoses that are homogeneous with respect to beneficiary profiles and resource usage. The DRG-weighting factor is multiplied by a second factor known as the standardized amount, which generaly reflects base-year hospital operating costs.[2]

Where the DRG weighting factor determines how Medicare reimbursements are distributed, the standardized amount determines the total amounts to be distributed. Accordingly, the validity of the base year cost data used to calculate the standardized amount has been the focus of our past and current audit work.

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[2] In fiscal years 1984-86, the second factor is a blend of hospital-specific, regional, and national rates. Payment amounts are adjusted annually to reflect an increase in market basket (the price of goods and services purchased by hospitals), and for such changes as hospital productivity and technology advances.

Unaudited Cost Reports Used To Determine PPS Payment Rates

To compute the PPS payment rates, the Social Security Amendments of 1983 directed HHS to use hospital cost data from the most recent cost reporting period for which data were available. To meet this requirement, HCFA used the Medicare hospital cost reports for reporting periods ended in 1981.

Normally, these yearly hospital cost reports are desk reviewed by insurance companies, called intermediaries, to assess their completeness and accuracy. Unallowable costs are disallowed. Each year a percentage of the cost reports are field audited, which can identify additional unallowable costs. Our analysis of reports submitted by intermediaries in fiscal years 1981 and 1982 shows that for those cost reports that were desk reviewed only, an average of 5.3 percent and 6.9 percent of the costs, respectivly, were disallowed.

Of the 5,501 hospital cost reports used to develop the PPS rates, however, only 62--about 1 percent--had been reviewed or audited at the time the rates were developed. Since then, HCFA has audited the 1981 reports but has not adjusted the PPS rates to reflect audit results.

As part of an ongoing assignment, we have attempted to determine the full impact of using the unaudited cost reports in establishing the PPS payment rates. To do this, we took a random sample of 418 field-audited cost reports from the original 5,501 cost reports, and compared the pre-audit cost data used by HCFA with HCFA's audited cost data.[3]

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[3] Our sample is projectable to the universe at the 95-percent confidence level ± 0.76 percent.

The comparision showed that substantial dollar adjustments were made to the 1981 cost reports for unallowable costs as a result of the audits. Adjustments were made for unallowable costs, such as federal income taxes, Hill-Burton free care costs, and directorship fees. One cost report, for example, was adjusted by about $1.3 million because federal income taxes, an unallowable cost, were claimed.

HCFA officials said that unaudited data rather than audited data were used because of the short time frame available in which to develop and implement PPS. They also said that they normally use unaudited data in making studies.

If audited cost data were used, we estimate that the fiscal year 1986 payments to hospitals could be reduced by about 3 percent or about $657 million.

Some Unallowable Capital Costs Are Included in the Rates

Our analysis of the data from the sampled cost reports also showed that some capital costs were inappropriately included in the PPS rate. All capital costs should have been excluded from the base year data because capital is paid for separately as a pass-through.

Capital costs include those facility costs associated with the buildings, furnishings, and equipment necessary to provide patient care. Depreciation for these assets and interest paid on funds borrowed to acquire them are also capital costs allowable under Medicare.

Our review of HCFA's methodology for developing the PPS rates showed that the national and regional hospital cost data include some capital costs related to the ancillary and special care units. In extracting data from hospital cost reports, HCFA did not identify capital costs allocated to the ancillary departments and the special care units from the general service departments, such as administrative, pharmacy, and laundry. Consequently, these capital costs had been erroneously included in the development of the rates, and hospitals are being doubly reimbursed for these costs.

HCFA officials agreed that these capital costs were included in the rates. An agency official said it would have taken a lot of time to identify these costs and they had a very short time frame to compute the rates.

Based on our analysis, we estimate that these unallowable capital costs have inflated the PPS payment rates by 1.3 percent. This would amount to $285 million in fiscal year 1986 Medicare expenditures.

There is some question, which we are still investigating, as to whether the adjustments HHS made to maintain budget neutrality corrected the problem of including these capital costs in the base year data. The Social Security Amendments of 1983 require that HHS adjust payment rates for 1984 and 1985 so aggregate payments for operating costs of inpatient hospital services are neither more nor less than HHS estimates would have been paid under prior legislation for the same services. This concept was called budget neutrality.

In response to an HHS Office of Inspector General draft report addressing the issue of inappropriately including capital in base year costs, HCFA's position was that the budget neutrality adjustments compensated for these costs. Our reading of the public record on this matter, however, indicates that no such adjustments were made. Nevertheless, we are continuing to investigate this matter.

Other Errors in Calculating PPS Rates

As part of our review of the 418 cost reports, we also found that HCFA made errors in coding and computing the information from the base year cost reports and in programming the computations using these data. In four cases, for example, HCFA understated the hospital's cost per discharge from $307 to $1,011. At this time, we are not sure of the exact extent or impact of these problems, but are continuing to address this question as part of our ongoing work.

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As a final note on the accuracy of HCFA's calculation of the standardized payment rates, we would like to point out that the information presented in this statement is from an ongoing assignment and it has not been finalized. However, this information is consistent with conclusions from several of our previous reports dealing with the reasonableness of PPS rates for individual services. For example, in a February 26, 1985, report on cardiac pacemaker surgeries,[4] we stated that the use of unaudited hospital cost reports for 12 hospitals reviewed resulted in medical supplies and laboratory services costs being overstated by about 5 percent. Until these problems are corrected, the Medicare program will continue to overpay for inpatient hospital services.

We believe an adjustment to the standardized amount to compensate for inflated base year costs would be appropriate, but at this time our data are still too preliminary for us to suggest a precise amount. We believe, however, that HHS, using our data as well as other information, such as the historic differences it has noted between audited and unaudited cost reports, could develop a rate to adjust base year costs. We would be pleased to work with HHS to help facilitate the development of such an adjustment factor.

As a longer term strategy, however, we believe HCFA should recompute the base rate using more current audited data reflecting hospitals' operating experiences under PPS.

RETURN ON EQUITY

The second issue we are discussing relates to Medicare payments to proprietary hospitals for return on equity. Medicare allows proprietary hospitals a return on equity capital invested and used in the providing patient care. Equity capital refers to the provider's investment in plant, property, and equipment related to patient care plus net working capital--the funds for necessary for day-to-day operation of patient care activities.

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[4] Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision (GAO/HRD-85-39, Feb. 26, 1985).

In 1983, the Congress reduced the allowable rate of return on equity capital. Before that time, Medicare paid proprietary providers a rate of return on all their hospital related equity capital equal to 1-1/2 times the rate earned on funds invested by Medicare's Hospital Insurance Trust Fund. The Social Security Amendments of 1983 reduced the rate of return for hospitals equity invested in providing inpatient hospital services to equal that earned by the Trust Fund--a reduction of one-third--but continued to allow the higher rate for hospitals' equity invested in providing outpatient services.

As with capital costs, return on equity is treated separately under Medicare's prospective payment system and continues to be passed through for reimbursement of reasonable costs. About $200 million, or 0.5 percent, of Medicare's total 1984 hospital reimbursement, was for return on equity payments.

We have a review underway to assess what happens to hospital costs and services when nonprofit hospitals are purchased by private sector businesses. In a review of 30 hospitals that have undergone such a change in ownership since 1980, we have found the added return on equity claimed by the hospitals averaged about $143 per Medicare discharge. The 30 hospitals claimed about $4.3 million annually for return on equity.

Proprietary institutions historically have financed capital expenditures through funds invested by owners in expectation of earning a return on their investment. Therefore, the return is needed to avoid the withdrawal of capital and to attract additional capital for expansion. At issue here is whether a return allowance should be explicitly provided for by Medicare, as under the present system, or whether proprietary hospitals' return should be obtained exclusively from their ability to provide services at a profit.

On March 21, 1984, we testified before this Committee on the effects of changes in provider ownership on capital costs. We pointed out that under Medicare's prospective payment system, hospitals can now realize a profit by holding their operating costs below the prospective payment level. In addition, we noted that some questions have been raised about whether there is a need to guarantee a return on equity in addition to the profits that can be earned by efficient management practices under PPS.

Under prospective payments, not-for-profit hospitals gain or lose on the basis of whether their costs are lower or higher than the prospective payments because currently Medicare does not provide them any specific return on equity allowance. Eliminating the return on equity allowance would therefore place proprietary and not-for-profit hospitals on the same footing in terms of Medicare's payment rules. This would be comparable to the situation for Medicare's end stage renal disease program, where there is no distinction between payment rates for proprietary and not-for-profit hospitals.

In addition, there is precedent for not explicitly reimbursing providers for a return on equity. Under Medicaid number of states do not include a return allowance in computing their payment rates for nursing homes.

The Social Security Admendments of 1983 required HHS to study and report to Congress by October 20, 1984, on proposals for inclusions of all capital-related costs in PPS. As of May 8, 1985, this study had not been released, and therefore, we have not had the opportunity to review the proposals.

We believe the question of whether to continue explicitly providing proprietary hospitals a return on equity allowance is one that merits congressional attention. PPS is designed to reward efficient hospitals. As with not-for-profit hospitals, proprietary hospitals that cannot provide services at Medicare rates should be expected to economize or absorb their losses. On the other hand, eliminating the explicit return provisions will, by definition, reduce profitability, which may have an impact on the availability of investor capital to the hospital industry. Both issues have to be considered in developing policies on this matter.

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This concludes my prepared statement. We will be happy to address any questions you may have.

ATTACHMENT I

ATTACHMENT I

COMPUTATION OF ESTIMATED SAVINGS (EXCLUDING WAIVER STATES) ACHIEVABLE BY USING CORRECTED COST DATA

	Fiscal year					5-Year
	1986	1987	1988	1989	1990	total
	(Billions)					
Estimated Medicare Hospital Payments Under PPS[1]	$48.142	53.357	59.107	65.609	72.826	299.041
Less Estimated Payments to Waiver States - 17.5%[2] Capital Costs - 7%[1] Direct Med. Ed. - 3%[1] Exempt Hospitals - 2%[1] Total - 29.5%	$14.202	15.740	17.437	19.355	21.484	88.217
Total Related to PPS Hospitals	$33.940	37.617	41.670	46.254	51.342	210.824
Hospital Specific Portion[3]						
Less 35% - 1986	$11.879					11.879
Less 10% - 1987		3.762				3.762
Total	$22.061	33.855	41.670	46.254	51.342	195.183
Savings to Medicare (Based on 4.27% Overstatement of PPS Rates)	$ .94	1.45	1.78	1.98	2.19	8.33

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[1] Estimated Medicare Hospital Payments are based on CBO staff estimates which include projections of future market basket plus 0.25 percent, and increases in both admissions and in the Medicare population.

[2] The estimated Medicare hospital payments were reduced to eliminate estimated payments for the hospitals in the four waiver states. A 17.5-percent reduction was computed by the HHS Office of Inspector General based on the ratio of total costs of hospitals in waiver states to total costs for all 5,631 hospitals in the fiscal year 1981 cost data.

[3] During fiscal years 1986 and 1987, PPS will continue to be phased in, and payment rates will be calculated by blending hospital-specific rates (based on hospital cost experience) and the federal PPS rate. The amounts shown represent the CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.

COMPUTATION OF ESTIMATED SAVINGS (INCLUDING WAIVER STATES) ACHIEVABLE BY USING CORRECTED COST DATA

	Fiscal year					5-Year
	1986	1987	1988	1989	1990	total
	(Billions)					
Estimated Medicare Hospital Payments Under PPS[1]	$48.142	53.357	59.107	65.609	72.826	299.041
Less Estimated Payments to Capital Costs - 7%[1] Direct Med. Ed. - 3%[1] Exempt Hospitals - 2%[1] Total - 12%	$ 5.777	6.403	7.093	7.873	8.739	35.885
Total Related to PPS Hospitals	$42.365	46.954	52.014	57.736	64.087	263.156
Hospital Specific Portion[2]						
Less 35% - 1986	$14.828					14.828
Less 10% - 1987		4.695				4.695
Total	$27.537	42.259	52.014	57.736	64.087	243.633
Savings to Medicare (Based on 4.27% Overstatement of PPS Rates)	$ 1.18	1.80	2.22	2.47	2.74	10.40

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[1] Estimated Medicare Hospital Payments are based on CBO staff estimates which include projections of future market basket plus 0.25 percent, and increases in both admissions and the Medicare population.

[2] During fiscal years 1986 and 1987, PPS will continue to be phased in, and payment rates will be calculated by blending hospital-specific rates (based on hospital cost experience) and the federal PPS rate. The amounts shown represent the CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.

Chairman **Stark**. Thank you very much.

Mr. Kusserow.

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LARRY SIMMONS, DIRECTOR, HEALTH CARE FINANCING AUDIT DIVISION

Mr. **Kusserow**. Thank you, Mr. Chairman.

I am Richard Kusserow, Inspector General, Department of Health and Human Services.

With me today is Larry Simmons, Deputy Assistant Inspector General for Auditing.

We welcome this opportunity to appear before you today to discuss our views on the inclusion of return on equity capital in Medicare's prospective payment rates used to reimburse hospials for inpatient care they provide to program beneficiaries. While this is a matter of national policy which only the Congress can decide, we believe that such payments for inpatient care should be discontinued.

I would like to summarize my statement and let the full text of the statement go for the record.

Chairman **Stark**. Without objection.

Mr. **Kusserow**. Very early in the Medicare Program under the original retrospective payment system, the Congress perceived a shortage of nursing home beds. As an incentive to increase the number and availability of these beds, Congress, through the Medicare Program, provided for payment of a reasonable return on equity capital invested by proprietary providers in facilities used to provide skilled nursing care.

Legislative history supports the position that the department should also pay a return on equity capital to proprietary hospitals.

In 1966, the department issued regulations authorizing the payment of a return on equity capital to all proprietary facilities as a cost of patient care. The rate of return to be applied to the unique equity base of each proprietary provider was set at the maximum allowed by law.

Though treated under the Medicare regulations as a cost, these returns on equity capital are actually profits. HCFA has traditionally paid the highest rates allowed by law. In 1983, according to a Congressional Budget Office estimate, Medicare paid about $300 million per year to proprietary providers for return on equity capital.

The Social Security Amendments of 1983 provided for a 3-year phase-in of a Medicare prospective payment system, PPS, for inpatient hospital services starting with each hospital's cost reporting period beginning on or after October 1, 1983.

However, capital expenses, which include return on equity, are specifically excluded from the PPS system until October 1, 1986.

Until then, capital expenses are to be reimbursed on a reasonable cost basis. But return on equity capital payments for hospital inpatient services only, are established at 100 percent—reduced from the previous maximum of 150 percent—of the average of the rates of interest, on obligations issued for purchase by the trust fund.

Over the past year we have considered a number of aspects of the present cost principles for reimbursing providers for their capital costs. We have identified a number of areas where these principles, or their application, are in our opinion, inapproproriate.

We believe these items ought not be continued or carried over into prospective payment rates for hospital inpatient services if they are to include payment for capital costs. We have kept the Department informed of our position on these issues.

Once again, with your permission, I would like to submit for the record a summary and copies of our reports giving our position on these capital cost issues including return on equity.

Chairman STARK. Without objection.

Mr. KUSSEROW. We have urged the Department to exclude any amounts for return on equity capital payments in their proposal for the prospective payment of capital costs. Based on past estimates, this would reduce Medicare's costs by about $200 million annually. We have taken this position for several reasons.

First, Medicare's prospective payment system is designed to encourage efficient operation and to allow hospitals that can provide services at costs less than the Medicare reimbursement rates to realize a profit. Both investor-owned and nonprofit institutions have this opportunity. Philosophically, we do not see any reason why proprietary hospitals should be allowed to profit through efficiency and good management—as are nonprofits—and at the same time, be guaranteed an additional profit in the form of return on equity capital payments—not paid to nonprofits—just by virtue of the type of the institution's ownership.

Second, nonprofit institutions have the equivalent of equity capital invested in their plants and equipment, yet they have never received return on equity capital payments. While there may be good arguments supporting this difference in reimbursement, Medicare's PPS tends to weaken many of these arguments, again, because of the opportunities for profits that now exist. And certainly, there is no need to attract capital investments in new hospitals, given the present surplus of hospital beds in the United States.

Third, while we admittedly have not explored the underlying reasons, the cost data used by HCFA to develop the prospective rates for hospitals showed that the average operating costs for proprietary hospitals were considerably lower than the average operating costs for all hospitals: 17 percent less per bed, 34 percent less per discharge, and 9 percent less per inpatient day. Payment of additional amounts to proprietary hospitals for return on equity capital might well be resulting in windfall profits for them.

Finally, Medicare's End Stage Renal Disease Program illustrates that payments for return on equity capital in a reimbursement system using prospectively set rates are not really necessary.

Medicare prospective rates paid to either free-standing—mainly proprietary—or hospital-based—mainly nonprofit—outpatient dialysis facilities/clinics do not include any allowance for return on equity capital. Yet the number of these facilities participating in the program has grown substantially since the final regulations implementing that incentive rate system were published in May 1983.

Mr. Chairman, this concludes our testimony. We stand ready to answer any questions you or the committee may have.

[The statement and a summary and copies of reports follow:]

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I WELCOME THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO DISCUSS OUR VIEWS ON THE INCLUSION OF RETURN ON EQUITY CAPITAL IN MEDICARE'S PROSPECTIVE PAYMENT RATES USED TO REIMBURSE HOSPITALS FOR INPATIENT CARE THEY PROVIDE TO PROGRAM BENEFICIARIES. WHILE THIS IS A MATTER OF NATIONAL POLICY WHICH ONLY THE CONGRESS CAN DECIDE, WE BELIEVE THAT SUCH PAYMENTS FOR INPATIENT CARE SHOULD BE DISCONTINUED.

WITH YOUR PERMISSION, MR. CHAIRMAN, I WILL MAKE THE FULL TEXT OF MY PREPARED STATEMENT AVAILABLE FOR THE RECORD.

BACKGROUND

VERY EARLY IN THE MEDICARE PROGRAM, THE CONGRESS INDICATED ITS CONCERN ABOUT A PERCEIVED SHORTAGE OF NURSING HOME BEDS. AS AN INCENTIVE TO INCREASE THE NUMBER AND AVAILABILITY OF THESE BEDS, CONGRESS, THROUGH THE MEDICARE PROGRAM, PROVIDED FOR PAYMENT OF A REASONABLE RETURN ON EQUITY CAPITAL INVESTED BY PROPRIETARY PROVIDERS IN FACILITIES USED TO PROVIDE SKILLED NURSING CARE. THE RATE OF RETURN IS NOT TO EXCEED ONE AND ONE-HALF TIMES (150 PERCENT OF) THE AVERAGE OF THE RATES OF INTEREST EARNED BY THE HOSPITAL INSURANCE TRUST FUND. WHILE THE LAW ESTABLISHES THE RETURN TO BE PAID TO PROPRIETARY NURSING HOMES, LEGISLATIVE HISTORY SUPPORTS THE POSITION THAT THE DEPARTMENT SHOULD ALSO PAY A RETURN ON EQUITY CAPITAL TO PROPRIETARY HOSPITALS.

IN 1966, THE DEPARTMENT ISSUED REGULATIONS AUTHORIZING THE PAYMENT OF A RETURN ON EQUITY CAPITAL TO ALL PROPRIETARY FACILITIES AS A COST OF PATIENT CARE. THE RATE OF RETURN TO BE APPLIED TO THE UNIQUE EQUITY BASE OF EACH PROPRIETARY PROVIDER WAS SET AT THE MAXIMUM ALLOWED BY LAW. THOUGH TREATED UNDER THE MEDICARE REGULATIONS AS A COST, THESE RETURNS ON EQUITY CAPITAL ARE ACTUALLY PROFITS. HCFA HAS TRADITIONALLY PAID THE HIGHEST RATES ALLOWED BY LAW. IN 1983, ACCORDING TO A CONGRESSIONAL BUDGET OFFICE ESTIMATE, MEDICARE PAID ABOUT $300 MILLION PER YEAR TO PROPRIETARY PROVIDERS FOR RETURN ON EQUITY CAPITAL.

RECENT CHANGES

THE SOCIAL SECURITY AMENDMENTS OF 1983 PROVIDED FOR A 3-YEAR PHASE-IN OF A MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR INPATIENT HOSPITAL SERVICES STARTING WITH EACH HOSPITAL'S COST REPORTING PERIOD BEGINNING ON OR AFTER OCTOBER 1, 1983. HOWEVER, CAPITAL EXPENSES - WHICH INCLUDE RETURN ON EQUITY - ARE SPECIFICALLY EXCLUDED FROM THE PPS SYSTEM UNTIL OCTOBER 1, 1986. UNTIL THEN, CAPITAL EXPENSES ARE TO BE REIMBURSED ON A REASONABLE COST BASIS. BUT RETURN ON EQUITY CAPITAL PAYMENTS - FOR HOSPITAL INPATIENT SERVICES ONLY - ARE ESTABLISHED AT "...THE AVERAGE OF THE RATES OF INTEREST, ...ON OBLIGATIONS ISSUED FOR PURCHASE BY THE...TRUST FUND." IN OTHER WORDS, THIS

PROVISION REQUIRES PAYMENT OF RETURN ON EQUITY CAPITAL ON HOSPITAL INPATIENT SERVICES AT 100 PERCENT OF THE AVERAGE TRUST FUND INVESTMENT RATES. THIS ONE-THIRD REDUCTION IN THE RETURN ON EQUITY CAPITAL, ATTRIBUTABLE TO HOSPITAL INPATIENT SERVICES - FROM 150 TO 100 PERCENT OF THE AVERAGE OF THE TRUST FUND INVESTMENT RATES - IS SAVING THE MEDICARE PROGRAM AN ESTIMATED $100 MILLION ANNUALLY. HOWEVER, THE 1983 AMENDMENTS DID NOT CHANGE THE ORIGINAL MAXIMUM OF 150 PERCENT OF THOSE RATES FOR HOSPITAL OUTPATIENT SERVICES AND SKILLED NURSING FACILITY CARE.

THE 1983 SOCIAL SECURITY AMENDMENTS ALSO PROVIDE THAT THE SECRETARY IS TO (1) STUDY THE METHODS BY WHICH PAYMENT FOR CAPITAL COSTS CAN BE INCORPORATED INTO PPS AND (2) MAKE PROPOSALS FOR LEGISLATION TO DO SO. "CAPITAL COSTS", AS USED HERE, INCLUDES SUCH COSTS AS DEPRECIATION ON FACILITIES AND EQUIPMENT, INTEREST ON BORROWED CAPITAL, RENT AND RETURN ON EQUITY CAPITAL PAYMENTS TO PROPRIETARY PROVIDERS. WITHIN HHS, RESPONSIBILITY FOR CONDUCTING THIS STUDY WAS ASSIGNED TO THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

OVER THE PAST YEAR WE HAVE CONSIDERED A NUMBER OF ASPECTS OF THE PRESENT COST PRINCIPLES FOR REIMBURSING PROVIDERS FOR THEIR

CAPITAL COSTS. WE HAVE IDENTIFIED A NUMBER OF AREAS WHERE THESE PRINCIPLES, OR THEIR APPLICATION, ARE, IN OUR OPINION, INAPPROPRIATE. WE BELIEVE THESE ITEMS OUGHT NOT BE CONTINUED OR CARRIED-OVER INTO PROSPECTIVE PAYMENT RATES FOR HOSPITAL INPATIENT SERVICES IF THEY ARE TO INCLUDE PAYMENT FOR CAPITAL COSTS. WE HAVE KEPT THE DEPARTMENT INFORMED OF OUR POSITION ON THESE ISSUES. WITH YOUR PERMISSION, I WILL SUBMIT, FOR THE RECORD, A SUMMARY AND COPIES OF OUR REPORTS GIVING OUR POSITION ON THESE CAPITAL COSTS ISSUES, INCLUDING THE RETURN ON EQUITY CAPITAL ISSUE, WHICH YOUR COMMITTEE MAY FIND OF INTEREST.

WE HAVE URGED THE DEPARTMENT TO EXCLUDE ANY AMOUNTS FOR RETURN ON EQUITY CAPITAL PAYMENTS IN THEIR PROPOSAL FOR THE PROSPECTIVE PAYMENT OF CAPITAL COSTS. BASED ON PAST ESTIMATES, THIS WOULD REDUCE MEDICARE'S COSTS BY ABOUT $200 MILLION ANNUALLY. WE HAVE TAKEN THIS POSITION FOR SEVERAL REASONS.

FIRST, MEDICARE'S PROSPECTIVE PAYMENT SYSTEM IS DESIGNED TO ENCOURAGE EFFICIENT OPERATION AND TO ALLOW HOSPITALS THAT CAN PROVIDE SERVICES AT COSTS LESS THAN THE MEDICARE REIMBURSEMENT RATES TO REALIZE A PROFIT. BOTH INVESTOR-OWNED AND NONPROFIT INSTITUTIONS HAVE THIS OPPORTUNITY. PHILOSOPHICALLY, WE DO NOT SEE ANY REASON WHY PROPRIETARY HOSPITALS SHOULD BE ALLOWED TO PROFIT THROUGH EFFICIENCY AND GOOD MANAGEMENT (AS ARE

NONPROFITS), AND AT THE SAME TIME, BE GUARANTEED AN ADDITIONAL PROFIT IN THE FORM OF RETURN ON EQUITY CAPITAL PAYMENTS (NOT PAID TO NONPROFITS) JUST BY VIRTUE OF THE TYPE OF THE INSTITUTION'S OWNERSHIP.

SECONDLY, NONPROFIT INSTITUTIONS HAVE THE EQUIVALENT OF EQUITY CAPITAL INVESTED IN THEIR PLANTS AND EQUIPMENT, YET THEY HAVE NEVER RECEIVED RETURN ON EQUITY CAPITAL PAYMENTS. WHILE THERE MAY BE GOOD ARGUMENTS SUPPORTING THIS DIFFERENCE IN REIMBURSEMENT, MEDICARE'S PPS TENDS TO WEAKEN MANY OF THESE ARGUMENTS, AGAIN, BECAUSE OF THE OPPORTUNITIES FOR PROFITS THAT NOW EXIST. AND, CERTAINLY THERE IS NO NEED TO ATTRACT CAPITAL INVESTMENTS IN NEW HOSPITALS, GIVEN THE PRESENT SURPLUS OF HOSPITAL BEDS.

THIRDLY, WHILE WE ADMITTEDLY HAVE NOT EXPLORED THE UNDERLYING REASONS, THE COST DATA USED BY HCFA TO DEVELOP THE PROSPECTIVE RATES FOR HOSPITALS SHOWED THAT THE AVERAGE OPERATING COSTS FOR PROPRIETARY HOSPITALS WERE CONSIDERABLY LOWER THAN THE AVERAGE OPERATING COSTS FOR ALL HOSPITALS: 17 PERCENT LESS PER BED; 34 PERCENT LESS PER DISCHARGE; AND 9 PERCENT LESS PER INPATIENT DAY. PAYMENT OF ADDITIONAL AMOUNTS TO PROPRIETARY HOSPITALS FOR RETURN ON EQUITY CAPITAL MIGHT WELL BE RESULTING IN WINDFALL PROFITS.

FINALLY, MEDICARE'S END STAGE RENAL DISEASE PROGRAM ILLUSTRATES THAT PAYMENTS FOR RETURN ON EQUITY CAPITAL IN A REIMBURSEMENT SYSTEM USING PROSPECTIVELY SET RATES ARE NOT REALLY NECESSARY. MEDICARE PROSPECTIVE RATES PAID TO EITHER FREE-STANDING (MAINLY PROPRIETARY) OR HOSPITAL-BASED (MAINLY NONPROFIT) OUTPATIENT DIALYSIS FACILITIES/CLINICS DO NOT INCLUDE ANY ALLOWANCE FOR RETURN ON EQUITY CAPITAL. YET THE NUMBER OF THESE FACILITIES PARTICIPATING IN THE PROGRAM HAS GROWN SUBSTANTIALLY SINCE THE FINAL REGULATIONS IMPLEMENTING THAT INCENTIVE RATE SYSTEM WERE PUBLISHED IN MAY, 1983.

THIS CONCLUDES MY TESTIMONY, MR. CHAIRMAN. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY WISH TO ASK.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date 13

From Richard P. Kusserow
Inspector General

Subject Capital Cost Issues That Need To Be Addressed In Developing Medicare Reimbursement Policy (ACN 14-52083)

To Robert B. Helms
Acting Assistant Secretary for
Planning and Evaluation

With the passage of prospective payment legislation in 1983, your office was given the task of studying ways to include capital-related costs in the prospective payment system (PPS). Many suggestions have been offered, ranging from maintaining the present capital pass-through system based on actual costs to folding capital into DRG rates through a capital add-on percentage. The basics of policy decisions are just starting to emerge.

As you know, my office devotes considerable effort to front-end reviews of planned policy changes to identify potential vulnerabilities and recommend preventive action. In the capital cost area, we have performed extensive audit work examining the application of current Medicare cost reimbursement principles. Our concern: whether current elements of reimbursable capital costs are appropriate for continuation or carryover as a base into a prospective payment mechanism. Since June 1984 this office has raised seven issues dealing with historical Medicare cost reimbursement for capital that, in our opinion, should be discontinued under retrospective cost reimbursement and not carried over into the merger of capital costs into DRG rates. These issues involve:

- gains on sales of assets
- asset revaluations
- return on equity capital
- waivers of interest income offsets
- depreciation allowances on Federally financed assets
- minimum salvage values on depreciable assets
- duplicate payment for capital costs.

In addition, our audits have determined that the established DRG rates for hospitals are duplicating certain capital costs being reimbursed on a pass-through basis under the prospective payment system. Two related problems caused this duplication.

This report summarizes each of these audit issues and, where applicable, discusses their effect on 1984 Medicare costs and the emerging policy options.

Issues Effecting Merger of Capital Costs Into DRG Rates

o Medicare regulations provide that gains resulting from sales of facilities such as hospitals and nursing homes will be shared up to the amount of depreciation previously included in Medicare allowable costs. Our audit at one intermediary disclosed that proprietary providers were incorrectly applying Federal regulations when computing Medicare's share of gains from sales of facilities. Specifically, providers were allowed to retroactively adjust their equity capital for non-Medicare depreciation, thus understating by $1.4 million the amount of reimbursement due the Medicare program.

Additional analysis of facility acquisitions and sales of one proprietary chain organization served by many intermediaries disclosed similar misinterpretations of Federal regulations. As a result, this organization may have inappropriately reduced the Medicare recoveries by another $13.5 million.

Accordingly, we recommended that HCFA issue guidance to intermediaries reiterating the fact that retroactive equity adjustments were not allowable. HCFA agreed and issued a clarification of Medicare policy. However, the clarification in essence waived retroactive application of the regulation due to its uneven application by the intermediaries and advocated prospective application and enforcement. We subsequently advised HCFA to rescind the policy clarification or we would refer the matter to the Comptroller General for resolution.

This condition at the one intermediary reviewed, overstated Medicare's 1984 costs by an estimated $1 million.

(Priority Audit Memorandum issued on February 2, 1985; Audit Control Number: 07-52000, Attachment 1)

- Medicare cost principles have allowed for the upward revaluation of assets when hospitals and nursing homes are sold at gains even though no increase occurred in the quality of the facilities or in the quantity of services offered. This office supported 1984 legislation which requires that, on sale of hospitals or skilled nursing facilities, the valuation of assets after change in ownership be limited to the allowable acquisition cost of the seller or buyer, whichever was less. Cost savings from this legislation was estimated at about $635 million over 5 years.

  This condition overstated Medicare's 1984 costs by an estimated $41 million.

  (Priority Audit Memorandum issued June 25, 1984; Audit Control Number: 07-42016, Attachment 2)

- With the advent of the Prospective Payment System in 1983, HCFA began reimbursing hospitals for Medicare patients on a per service instead of a cost of service basis. Under this payment system, hospitals can realize a "profit" whenever they keep their operating costs below the predetermined Medicare reimbursement amounts.

  In spite of this incentive and the fact that 1981 cost data used to develop the prospective payment rates showed that proprietary hospitals already had considerably lower average operating costs than the average of all hospitals, the Medicare program continues to reimburse proprietary hospitals about $200 million annually for return on equity capital. As the national rates are phased in under the prospective payment system, continuing return on equity capital payments may result in windfall profits to proprietary hospitals. Accordingly, continuation of return on equity capital payments should not be considered in developing a future payment system for hospital capital costs.

  This condition overstated Medicare's 1984 costs by an estimated $200 million.

  (Priority Audit Memorandum issued on July 9, 1984; Audit Control Number: 07-42019, Attachment 3)

- Under Medicare cost reimbursement principles, providers are generally required to reduce interest expenses claimed for reimbursement by interest income. An exception, involving interest on funded depreciation, was granted to encourage providers to set aside funds for future capital needs. Our analysis indicated this loophole is no longer appropriate because of a national surplus of hospital beds, lack of predicted bed shortages in the near future, Medicare payments for interest and depreciation on hospital buildings currently in use. Its closure would save the Medicare and Medicaid programs an estimated $4.7 billion over the next 5 years.

This condition overstated Medicare's 1984 costs by an estimated $464 million.

(Draft Report issued on December 13, 1984; Audit Control Number: 09-52032, Attachment 4)

o To encourage donations to hospitals, HCFA waived the cost principle requiring that gifts and income earned from the gifts be offset against operating costs. However, we found no evidence that offsetting the interest earned from donations would discourage private gifts as long as the donations themselves were not offset against operating costs. We are in the process of estimating the dollar savings that would accrue to the Medicare and Medicaid programs with the closing of this loophole.

(Priority Audit Memorandum issued on December 24, 1984; Audit Control Number: 09-52002, Attachment 5)

o Paying providers, particularly hospitals, depreciation costs on assets financed with Hill-Burton grants or other Federal funds results in double Federal participation in the cost of those health facilities. By eliminating the depreciation allowance on Federally financed assets and excluding such depreciation from any system of prospective payment for capital costs, HCFA can save the Medicare and Medicaid programs about $720 million in future years.

This condition overstated Medicare's 1984 costs by an estimated $34 million.

(Audit Report issued on December 27, 1984; Audit Control Number: 09-52020, Attachment 6)

o The Medicare program reimburses providers about $1.6 billion annually for buildings and building service equipment depreciation. But, most providers do not reduce the cost of depreciable assets for salvage value before claiming depreciation as required by Medicare regulations, thus significantly overstating the depreciable cost of assets at most Medicare participating hospitals. By requiring that providers establish a minimal salvage value of 10 percent, HCFA could reduce expenditures by about $160 million annually as well as realize substantial savings by reducing the associated interest costs. At a 10 percent annual interest rate, the interest cost on $160 million for 10 years would be $236 million.

This condition overstated Medicare's 1984 costs by an estimated $160 million.

(Priority Audit Memorandum will be issued during May 1985; Audit Control Number: 07-52004, Attachment 7)

Duplicated Costs in DRG Rates and Pass-Through Amounts

o Under the prospective payment system, hospital capital costs are reimbursed on a retrospective basis as a pass-through cost. Reimbursement for these costs is in addition to the DRG payment per discharge. Our review disclosed that about $1 billion in capital costs was inappropriately included in the 1981 cost report data used to calculate the 1984 DRG rates. This occurred because HCFA instructions did not exclude certain capital costs allocated through the hospital's general services cost centers to ancillary services and special care units. Therefore, providers were receiving duplicate reimbursement for capital costs of about $420 million in 1984.

We recommended that HCFA rebase DRG amounts using hospitals' 1982 audited cost data, which excludes capital costs, in order to eliminate this duplicative payment. Implementation of this recommendation will save the Medicare program approximately $2.8 billion over the next 5 years.

HCFA indicated that it knew there was capital in the base year costs but that adjusting the rates for budget neutrality under the Tax Equity and Fiscal Responsibility Act largely eliminated any potential overpayments. OIG does not agree wih HCFA's position.

(Priority Audit Memorandum issued January 15, 1985; Audit Control Number: 07-52008, Attachment 8)

o We also reviewed selected hospitals' audited 1982 or 1983 base year cost reports. Audit determined that $966 million of previously unidentified capital costs were classified and charged as operating costs during the DRG calculation base period. Therefore, the Federal portion of the 1984 DRG rates was overstated to the extent that these capital costs remained in the operating cost base - resulting in duplicate reimbursement for capital costs.

To correct this problem, we again recommended that HCFA rebase DRG rates using 1982 or 1983 hospital specific base year cost reports. Rebasing the DRG rates in this manner will save Medicare approximately $2.25 billion over 5 years.

(Priority Audit Memorandum to be issued during May 1985; Audit Control Number: 07-52011, Attachment 9)

Under the total revenue proposal for incorporating capital into PPS, these two problems would be corrected.

Based on these findings, we believe past Medicare payments of capital costs to providers have been excessive. Eliminating these cost features that have caused added Medicare outlays would, of course, lower the ratio of hospitals' capital costs to operating costs well below the national average of seven percent. Discontinuing the cost features our audits have questioned would reduce the ratio of capital costs to about five percent, two percentage points lower than the historical average.

We will be happy to meet with you or your staff to discuss these matters more fully.

Attachments

ATTACHMENT 1
Page 1 of 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General

FEB 2 1984

Memorandun

Date

From Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum - Correct Computation of Medicare Program Gains from Sales of Hospitals and Skilled Nursing Homes Could Save Millions (ACN 07-42000)

To
Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Based on our preliminary findings, we believe that Medicare may be losing millions of dollars because intermediaries are improperly computing the Federal share of gains from the sale of hospitals and skilled nursing homes by proprietary providers. At one intermediary alone, we found Medicare's share of gains was improperly reduced by $1.4 million.

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Medicare regulations provide that gains resulting from sales of such facilities will be shared up to the amount of depreciation previously included in Medicare allowable costs. Our review at one intermediary (Mutual of Omaha) showed that proprietary providers are incorrectly applying Federal regulations when computing Medicare's share of gains from sales of facilities. Specifically, providers were being allowed to adjust their equity capital for non-Medicare depreciation (a procedure permitted when accelerated depreciation is used) when in fact they claimed straight line depreciation. Not only is this practice contrary to regulations, it is inequitable in our opinion, and significantly understates the reimbursement due the Medicare program. In this regard, gains on the sale of 11 hospitals and 9 skilled nursing homes were improperly reduced by $1.4 million.

Eight of the hospitals mentioned above were acquired by Hospital Corporation of America (HCA) -- a large proprietary chain organization. This organization is served by many other intermediaries. An official of HCA stated it is their practice to reduce Medicare reimbursement in the manner discussed above and that they have consistently followed this practice without any intermediary disallowances. For hospitals acquired, HCA usually assumed the seller's liability for refunding Medicare's share of gains.

This is important because HCA acquired or sold 125 hospitals during the period January 1978 through May 1983. Assuming that the practice of retroactively adjusting equity was followed for all 125 acquisitions or sales, we estimate that Medicare recoveries may have been inappropriately reduced by about $13.5 million. Further, if these intermediaries allowed similar adjustments by other proprietary providers, the total reduction in payments to the Medicare program would be considerably larger.

As a result of our review, Mutual of Omaha requested an opinion from HCFA's Division of Institutional Services Reimbursement concerning this practice. The Division issued a letter to the intermediary in September 1983 stating that OIG's position was correct and that the practice was not in accordance with regulations. HCFA restated this position in a letter dated November 21, 1983 to HCA.

We believe HCFA should immediately remind all intermediaries of the proper procedures for treating gains on sales of medical facilities. Also, intermediaries should be instructed to reopen cost reports, where necessary, and compute the proper Medicare program reimbursement.

We would appreciate your comments on this matter by February 29.

ATTACHMENT 2
Page 1 of 20
Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

JUN 25 1984

From /s/ Richard P. Kusserow
Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum - Need to Limit the Revaluation of Assets After Sale of Hospitals and Nursing Homes (Audit Control Number 07-42016)

To Carolyne K. Davis, Ph.D.
Administrator, Health Care
Financing Administration

The Office of Inspector General has for several years been concerned about the frequent sale of hospitals and nursing homes and the effect on Medicare and Medicaid program costs. As you know, Medicare and, in many states, Medicaid reimbursement principles presently allow buyers to revalue assets when hospitals and nursing homes are sold at gains even though there may be no increase in the quality of the facilities or the quantity of services.

In contrast, hospitals and nursing homes which are not sold are limited to original costs for reimbursement purposes unless, of course, they are remodeled or expanded. While construction adds to the industry in terms of new facilities, equipment, and technologies, sales generally only increase the cost of existing facilities.

To date, our review has been directed primarily towards determining the magnitude of hospital and nursing home mergers and acquisitions, the effect the sales and resales have on capital costs (primarily depreciation, interest expense; and, in the case of proprietary providers, return-on-equity capital), and the effectiveness and appropriateness of Medicare reimbursement policies relating to capital costs.

Based on our review, we've concluded that:

-- Hospital and nursing home mergers and acquisitions have been substantial since the implementation of the Medicare program--and especially since 1978. Many hospitals have been sold twice and some as many as 4 times in the last 15 years.

-- Many hospitals and nursing homes were sold at substantial gains. In fact, the selling prices often exceeded the sellers original acquisition cost including improvements.

-- Hospital and nursing home sales and resales have resulted in significant cost increases to the Medicare and Medicaid programs without a commensurate change in the quality of facilities or the quantity of services.

cc:
OIG/ES ✓Control File
Reading File Subject File

-- Present Medicare reimbursement policies have not effectively restricted capital cost increases. In fact, the policies may even encourage growth in capital costs.

-- Medicare regulations and HCFA's implementing instructions do not provide intermediaries sufficient guidance in establishing the cost basis of assets after sale. As a result, intermediaries, at least in most cases we reviewed, have not properly limited the revaluation of assets after sale.

-- Salvage values for depreciation purposes were not always established after hospitals were sold. As a result, depreciation costs may be higher than necessary.

-- Significant portions of the gains on sale of hospitals were not being recovered by the Medicare program because (1) assets were revalued in such a way that the gains were not fully recoverable or (2) the gains were improperly offset against increases in equity capital. Furthermore, gains on sale, especially those involving proprietary chain organizations, were not recovered in a timely manner--usually not until 2 or more years after sale. As a result, the value of the recovery was "eroded" due to the time value of money.

Recently, at a joint hearing before the Subcommittees on Oversight and Health of the House of Representatives Committee on Ways and Means, we presented testimony in support of a proposal to limit the revaluation of assets after the sale of hospitals and nursing homes. The Congressional Budget Office testified at the hearing that they estimated such a proposal would save the Medicare and Medicaid programs about $830 million over a 5-year period.

In subsequent testimony, HCFA representatives stated that this proposal was undesirable because it would result in losses to the Medicare program, at least in the short term. The HCFA representatives were asked to provide the data on which they based their position.

We obtained the data and analyzed it. We found that the data was predicated on the assumption that if Medicare limited a buyer's cost basis in an asset for reimbursement purposes to the seller's book value, the book value would also have to be recognized as the selling price for Medicare purposes. As a result, no gain from the sale would occur and the Medicare program would incur a loss to the extent of any gain it would have otherwise shared in.

In our opinion, this assumption is invalid and, furthermore, is contrary to existing Medicare reimbursement principles. Consequently, we believe the Medicare program would realize substantial savings if the proposal was adopted. However, even using HCFA's assumption, our analysis shows that the Medicare program would still realize significant savings if the proposal was adopted.

The House of Representatives and Senate have proposed legislation to prevent the revaluation of assets after sale. The purpose of this memorandum is to suggest that HCFA reconsider its position in this matter and support the proposed legislation.

More details relating to the matters discussed above are included in the attachment to this memorandum. Also, if you so desire, members of my staff are available to discuss any of these matters with your staff. In any case, we would appreciate receiving your written comments within 30 days from the date of this memorandum.

Attachment

NEED TO LIMIT THE REVALUATION OF ASSETS AFTER SALE OF HOSPITALS AND NURSING HOMES

Capital costs consist primarily of depreciation and interest expense. Other items such as insurance and, in the case of proprietary providers, real estate taxes and return-on-equity capital are also classified as capital costs. Currently, the Medicare and, in many states, the Medicaid program reimburses capital costs on a cost basis. Capital costs relate to buildings as well as building service equipment (installed or fixed equipment such as elevators, boilers, air conditioning equipment, etc.) and movable equipment (beds, chairs, etc.). When hospitals or nursing homes are sold at more than book value (undepreciated cost at the time of sale) capital costs and, consequently, the costs to the Medicare program and, in many states, the Medicaid program increase.

Legislation has been introduced in both the House of Representatives and the Senate that would limit revaluation of assets after sale for Medicare reimbursement purposes to the net book value (or undepreciated value) of the asset on the seller's books at the time of sale. The purpose of the legislation is to limit capital costs increases due to sales of hospitals and other facilities.

MERGERS AND ACQUISITIONS

Of the nation's approximate 6,900 hospitals, at least 1,035 are owned, leased, or managed by proprietary chain organizations. Total acquisitions were not readily identifiable; however, we did identify acquisition of at least 518 hospitals by six major chain organizations during the years 1967 through 1983. About 68 percent or 352 acquisitions occurred since 1978.

Numerous hospitals were sold more than once during the period. Also, many of the acquisitions involved purchases of smaller chains by larger chains. In some instances, a hospital was acquired by the same chain more than once. For example, a hospital owned by chain A was sold to chain B in 1972. Chain A subsequently acquired the hospital from chain B in 1981 and sold the hospital to chain C in 1982.

Effect of Mergers and Acquisitions

Our review indicated that most sales resulted in substantial gains to the sellers. For example, sales of proprietary owned hospitals during the period 1979 to 1981 at two Medicare intermediaries showed that the average selling prices exceeded the sellers' average undepreciated cost by a considerable amount--from 91 to 171 percent (See Appendix A). Gains on individual hospitals ranged from $744,000 to $15.9 million. Two hospitals were sold twice during this period. One hospital, with an undepreciated value of $402,500, was sold in 1980 for $1.31 million--a gain of about $908,000. About 9 months later the hospital was sold again for $2.5 million--a gain of about $1.2 million.

Also, our review of nursing home sales from 1977 through 1981 at one intermediary showed that all sales resulted in gains and, in all but one instance, the selling price exceeded the original acquisition cost plus improvements. Gains on the nursing home sales, which involved 15 nursing homes, was $9.1 million.

Although the above increases are dramatic, they do not show the full effect higher asset values have on the Medicare and Medicaid programs. This is because higher asset values not only effect the amounts charged for annual depreciation but the financing charges associated with higher values are increased as well--interest costs if the funds were borrowed and return-on-equity if the funds were invested.

Our detailed review of two hospital sales illustrate the full effect revaluation of assets after sale had on Medicare program costs. At one hospital capital costs per patient day increased from $32.81 to $102.32, or 212 percent, after sale while at the other hospital capital costs per patient day increased from $31.79 to $115.08, or 262 percent, after sale. Total Medicare costs at the two hospitals increased $5.3 million and $1.5 million respectively after sale. And, most of the increases--over 70 percent--resulted from increased capital costs. (See Appendix B.)

EFFECTIVENESS OF MEDICARE REIMBURSEMENT PRINCIPLES DEALING WITH CAPITAL COSTS

Medicare regulations contain several provisions which address the sale of hospital and nursing homes. One provision requires that when assets (buildings and equipment) are sold, intermediaries are to limit the new cost basis to the lower of the selling price, fair market value, or current reproduction cost adjusted for straight-line depreciation to time of purchase. Current reproduction cost is defined as the cost at current prices, in a particular locality or market place, of reproducing the asset in kind. Acquisition cost in excess of the above limitation is considered goodwill and reimbursement for related capital costs is unallowable.

Although the regulations require specific action on the part of intermediaries, HCFA instructions provide little guidance on how the regulations are to be applied. That is, should intermediaries independently ensure that the selling price does not materially exceed the current reproduction cost of the assets sold by obtaining an appraisal or by applying a construction price index? Consequently, intermediaries rely on appraisals obtained by the buyers or, if no appraisals are made, they rely on the sales agreement to establish the cost basis of assets after sale. Our review showed that appraisals were generally obtained after the sale or after the sales price had been agreed to and were usually obtained to allocate the purchase price to various classes of assets acquired. Acceptance of these appraisals or a sales agreement where an appraisal was not obtained without independent evaluation does not provide assurance that the selling price did not exceed the depreciated current reproduction costs. As a result, a portion of the buyer's cost basis may be unallowable or at least questionable for Medicare and Medicaid reimbursement.

The significance of this problem is illustrated by our review of seven hospital sales. For these sales, the appraised values exceeded depreciated reproduction costs by about $27 million, or 30 percent. The appraised values were higher because:

-- Four appraisals used current hospital square feet requirements rather than the actual square footage of purchased hospitals to compute reproduction costs. This increased the value of the hospitals $16 million--17 to 39 percent per hospital. Other appraisals used actual square feet to compute reproduction costs. Appraisals from one company used actual square feet in one instance and current hospital requirements in others.

-- Five appraisals used a 50-year life for buildings and building service equipment to determine depreciated reproduction costs. The 50-year life was used instead of the lesser life previously used or allowed for Medicare purposes. This increased the value of the hospitals from 7 to 15 percent. Other appraisals used 40-year lives or less to depreciate building service equipment.

-- One appraisal was revised to transfer 50 percent of the building service equipment value to the cost of the building. Since the depreciable life is longer for buildings, the combined cost basis of the building and building service equipment was increased by 6 percent.

-- One appraisal increased the value of a hospital by $1.4 million, or about 9 percent, on the basis that the buyer had higher quality construction standards than that of the facility purchased.

Using sales agreements to establish the buyer's asset cost basis may result in overvalued assets, as well. For example, we noted one instance where a hospital with an undepreciated value of about $402,500 sold for $1.31 million--a gain of about $908,000, or 226 percent. About 9 months later, the hospital sold again for $2.5 million--a gain of about $1.2 million, or 91 percent.

In addition, Medicare regulations and HCFA instructions provide that asset costs for depreciation purposes are to be reduced by the estimated salvage value, if any. However, our review showed that asset costs after sales were not reduced for salvage valve. If asset costs are not reduced by the estimated salvage valve, depreciation costs to the Medicare program may be higher than necessary.

Medicare regulations also provide that when assets are sold for more than book value, the Medicare program is entitled to share in the gain. The portion of the gain in which Medicare shares is limited to the amount of accumulated depreciation previously claimed for Medicare reimbursement. Any financing charges previously claimed by the seller, however, are not subject to recovery.

Our preliminary work at two Medicare intermediaries showed that although portions of the gains were recovered when facilities were sold, the recoveries usually did not occur until 1 to 3 years after sale. This was because of (1) delays in getting the final cost reports, (2) the need to perform a final audit, or (3) the time required to decide whether the transaction was actually a sale or stock acquisition. Consequently, the value of the recovery--due to the time value of money--would be substantially less than actual payments to the providers.

In addition, we found that the Medicare program did not share in the full amount of the applicable gain. This results from several circumstances. First, some accumulated depreciation may apply to a period prior to the seller's participation in the Medicare program. Secondly, and more importantly, in most sales all assets were not proportionately revalued on the basis of the selling price. Some assets were revalued (restored to a depreciable base above book value) little or none. Other assets were substantially revalued, sometimes twice as high as the seller's original acquisition cost. Since the recoverable gain is limited to accumulated depreciation, for those asset classes not substantially revalued little or no gain would be recovered. For those assets which were substantially revalued, the recoverable gain would be limited to the accumulated depreciation (difference between the seller's book value and original acquisition cost).

The following is a hypothetical example which illustrates the effect of the latter practice on the amount of a gain recoverable by Medicare from the sale of a hospital.

Asset Class	Acquisition Cost	Accumulated Depreciation	Book Value	Sales Price	Total Gain	Portion of Gain Subject to Recovery
		(--in millions--)				
Building	$6.0	$1.5	$4.5	$10.0	$5.5	$1.5
Building Serv. Equipment	2.0	1.0	1.0	1.5	.5	.5
Moveable Equipment	2.5	2.0	.5	.5	--	--
Totals	$10.5	$4.5	$6.0	$12.0	$6.0	$2.0

As shown, the total accumulated depreciation was $4.5 million. However, only $2 million is subject to recovery. The remaining $2.5 million is not subject to recovery because it is "sheltered" by associating most of the gain with the building and little or none with the other asset classes.

The following schedule illustrates how this practice actually affected the accumulated depreciation recoverable for 10 hospitals we reviewed.

	Total Depreciable Assets (In Millions)
Total Acquisition Cost	$ 95.6
Accumulated Depreciation	23.5
Total Book Value	$ 72.1
Total Sales Price	138.5
Total Gain	$ 66.4
Portion of Gain (Accumulated Depreciation) Medicare Program Participated in	$ 23.5
Portion of Gain (Accumulated Depreciation) of Assets Not Recoverable For Reason Discussed Above (45%)	10.6
Portion of Gain Recoverable (55%)	$ 12.9

As shown, only $12.9 million, or 55 percent, of the accumulated depreciation of $23.5 million that the Medicare program participated in was subject to recovery (gain adjustment). As discussed in the next section, these conditions materially affect HCFA's assessment of the legislation pending in Congress.

In addition, we noted that some intermediaries were not recovering the full portion of the gain attributable to the Medicare program. Specifically, intermediaries were allowing providers to retroactively adjust their equity capital for the non-Medicare depreciation applicable to the gain. This increased the return-on-equity capital payments to the providers thereby reducing the recovery to the Medicare program. This further reduced the share of the gain due to the above hospital sales which is recoverable by Medicare by $1.2 million.

EVALUATION OF HCFA'S POSITION ON PENDING LEGISLATION

At a joint hearing before the Subcommittees on Oversight and Health of the House of Representatives Committee on Ways and Means, HCFA testified on a proposal to limit revaluations of assets for Medicare purposes after sale of hospitals and nursing homes. HCFA's position, as stated by the representatives at the hearing, was that if buyers were not allowed to revalue assets after an acquisition, Medicare would no longer be able to share in the gain the seller realized on the sale. The representatives indicated that consistency suggests that the asset valuation for Medicare purposes should be the same for both the seller and buyer. Consequently, if the buyer's cost basis in an asset is the seller's book value then the book value would also have to be considered as the selling price for the purposes of computing a gain. They indicated that it is questionable whether they could sustain on challenge a policy that provides for sharing in a seller's gain on one hand but does not permit the buyer to revalue assets based on the purchase price on the other. Based on this assumption, the HCFA representatives presented data to illustrate that the proposal would result in increased costs to the Medicare program, at least in the short term.

We do not agree with HCFA's position for several reasons. First of all, the buying and selling of a hospital is two separate transactions for Medicare reimbursement purposes. Therefore, limiting the buyer's asset cost basis (valuation) for reimbursing capital costs to the undepreciated value of the facility does not affect the gain realized by the seller. But more importantly, HCFA's position is contrary to current Medicare policy which provides that the asset valuation need not be the same for both the buyer and seller. Consequently, if the proposal was adopted, we believe the gain would be recoverable and that the Medicare program would realize substantial savings. However, even using HCFA's assumption that Medicare could no longer share in gains from the sale of assets--with which we do not agree--we believe the proposal would still result in significant savings to the Medicare and Medicaid programs and not in a loss as suggested by HCFA.

Medicare Policy

Current Medicare policy treats sharing in the seller's gain and the buyer's revaluation of purchased assets as two separate and distinct occurrences. From the perspective that the sharing in the seller's gain and the buyer's revaluation of acquired assets are two distinct occurrences, changing one of them would not affect the other. This precedent was established when HCFA revised the Medicare regulations in 1970 to limit the cost basis of assets acquired after July 31, 1970, to the lower of the selling price, fair market value, or the current reproduction cost depreciated on a straight-line basis over the life of the assets to the time of sale. In addition, Section 104.14B of HIM-15 states:

> "B. If the facility was being operated under the program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new provider in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is

> limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price."

This provision clearly provides that the buyer's cost basis for claiming capital costs of assets sold at prices in excess of the depreciated current reproduction cost can be different than the seller's basis for computing a gain. Consequently, we believe that Medicare's share of gains would be recoverable and that HCFA's position is contrary to this policy--that the asset value need not be the same for both the buyer and seller.

Capital Cost Savings

We analyzed the data presented by HCFA. Theoretically, the results were possible based on the assumptions and limited period used. However, as discussed above, we believe the gain from sale would be recoverable under the proposal.

In the data presented by HCFA, three illustrations were used to show that in the short term, the proposal to limit revaluation of assets after sale would result in increased costs to the Medicare program. We evaluated these illustrations and computed the savings on the basis that the gain was recoverable.

Shown below is one of HCFA's illustrations along with our computations.

HCFA's Illustration 1

> A hospital with a book value of $640,000 is sold on October 1, 1984, for $2 million dollars. The purchaser finances $1.6 million over 30 years at 11 percent interest. The remaining $400,000 of the purchase price is financed by equity capital. The original cost of $1.0 million was being depreciated over 40 years (straight-line) to a salvage value of $100,000. There was no existing debt at the time of acquisition. The purchaser depreciates the acquisition price over 40 years (straight-line) to a salvage value of $200,000.

COMPARISON OF ALLOWABLE CAPITAL COSTS AFTER SALE UNDER CURRENT AND PROPOSED LAWS

	HCFA's COMPUTATION			OIG's COMPUTATION		
	FY 85	FY 86	FY 87	FY 85	FY 86	FY 87
	(In Thousands)			(In Thousands)		
CURRENT LAW						
Depreciation	$ 45	$ 45	$ 45	$ 50	$ 50	$ 50
Interest	176	175	174	176	175	174
Return on Equity	44	45	46	44	45	46
Total	$ 265	$ 265	$ 265	$270	$270	$ 270
PROPOSED LAW						
Depreciation	$ 22	$ 22	$ 22	$ 16	$ 16	$ 16
Interest	26	26	26	26	26	26
Return on Equity	44	45	46	44	45	46
Total	$ 92	$ 93	$ 94	$ 86	$ 87	$ 88
Capital cost savings						
1st year	$ 173	$ 172	$ 171	$184	$183	$ 182
2nd year		173	172		184	183
3rd year			173			184
Annual savings assuming a similar transaction takes place each year	$ 173	$ 345	$ 516	$184	$367	$ 549
Gain Recovery	(360)	(360)	(360)	198	198	198
Cost savings (loss)	$(187)	$(15)	$ 156	$382	$565	$ 747
Cumulative 3-year effect--Cost savings (loss)			$(46)			$1,694

As shown, we concluded that over the 3-year period costs would decrease by $1,694,000 rather than increase by $46,000 as suggested by HCFA's computations. The savings to the Medicare program would depend on the level of Medicare patient utilization.

In our computations, we adjusted HCFA figures where actual experience of sales reviewed materially affected HCFA's assumptions. Although we did not fully agree with the amounts HCFA used for interest and return-on-equity in the last 2 years, we did not make any adjustments since they would not materially affect the end results. Our adjustments included:

- showing the gain as recoverable under the proposed law but reducing the amount to reflect recovery experience based on the sales we reviewed. As discussed previously only about 55 percent of the gains were subject to recovery. Accordingly only about 55 percent of the $360,000 or $198,000 would be recoverable.
- computing depreciation (Current Law) based on the total purchase price of $2 million versus the $1.8 million since sales reviewed indicated that buyers were not reducing their acquisition cost by a salvage value.
- computing depreciation (Proposed Law) based on the book value of $640,000 divided by 40 years. In the illustration, HCFA stated the buyer was depreciating the acquisition price over 40 years. However, the depreciation used by HCFA was based on the seller's acquisition cost of $1 million less salvage value of $100,000.

Our evaluation of the remaining two illustrations presented by HCFA are included in Appendix C. As with the above, our computations show that the Medicare program would realize substantial savings in these situations under the proposal as well.

In addition, we analyzed HCFA's illustrations on the basis that the Medicare program would not share in the gains from the sales. As previously discussed, the timeliness of gain recoveries and amount of gains actually realized varied materially with what could theoretically happen. Consequently, we believe that on the basis of actual circumstances the Medicare program would achieve substantial savings in the first three years under the proposal even if Medicare did not share in the gains.

Shown below is one of HCFA's illustrations along with our analysis.

COMPARISON OF ALLOWABLE CAPITAL COSTS AFTER SALE UNDER CURRENT AND PROPOSED LAWS

	HCFA's COMPUTATION			OIG's COMPUTATION		
	FY 85	FY 86	FY 87	FY 85	FY 86	FY 87
	(In Thousands)			(In Thousands)		
CURRENT LAW						
Depreciation	$ 45	$ 45	$ 45	$ 50	$ 50	50
Interest	176	175	174	176	175	174
Return on Equity	44	45	46	44	45	46
Total	$ 265	$ 265	$ 265	$ 270	$ 270	$ 270
PROPOSED LAW						
Depreciation	$ 22	$ 22	$ 22	$ 16	$ 16	$ 16
Interest	26	26	26	26	26	26
Return on Equity	44	45	46	44	45	46
Total	$ 92	$ 93	$ 94	$ 86	$ 87	$ 88
Capital cost savings						
1st year	$ 173	$ 172	$ 171	$ 184	$ 183	$ 182
2nd year		173	172		184	183
3rd year			173			184
Annual savings assuming a similar transaction takes place each year	$ 173	$ 345	$ 516	$ 184	$ 367	$ 549
Gain Recovery	(360)	(360)	(360)	(198)	(198)	(198)
Cost savings (loss)	$(187)	$(15)	$ 156	$(14)	$ 169	$ 351
Cumulative 3-year effect--Cost savings (loss)			$(46)			$ 506

In our computations, we made the same adjustments as in our previous schedule except that we used HCFA's assumption that the gain was not recoverable. Our analysis shows that rather than an increase in costs of $46,000 as suggested by HCFA, cost would actually decrease by $506,000 over the 3-year period even if Medicare did not recover the gains. Our analysis of HCFA's other illustrations showed that costs would decrease in these situations as well.

HOSPITAL ACQUISITIONS
BY
PROPRIETARY ORGANIZATIONS

		AVERAGE			
				COST INCREASE	
YEAR	NUMBER OF SALES	SELLERS' UNDEPRECIATED COST	SELLING PRICE	AMOUNT	PERCENT
1979 1/	3	$ 3,353,000	$ 6,399,100	$ 3,046,100	91
1980 2/	4	$ 3,906,800	$ 10,598,900	$ 6,692,100	171
1981 2/	14	$ 7,003,000	$ 14,942,900	$ 7,939,900	113

1/ Sales at one intermediary.

Sales at two intermediaries.

CAPITAL COST INCREASES
HOSPITAL

	YEAR BEFORE SALE	YEAR AFTER SALE	INCREASES AMOUNT	INCREASES PERCENT
HOSPITAL A				
Capital Costs Per Patient Day	$ 32.81	$ 102.32	$ 69.51	212
Total Medicare Costs (MILLIONS)	$ 32.4	$ 37.7	$ 5.3	
Portion of Medicare Cost Increase Due To Increased Capital Costs (MILLIONS)			$ 3.9	
HOSPITAL B				
Capital Costs Per Patient Day	$ 31.79	$ 115.08	$ 83.29	262
Total Medicare Costs (MILLIONS)	$ 6.3	$ 7.8	$ 1.5	
Portion of Medicare Cost Increase Due To Increased Capital Costs (MILLIONS)			$ 1.1	

HCFA's ILLUSTRATION #2

Sale Description

A hospital with a book value of $775,000 is purchased on October 1, 1984, for $1.5 million. The purchaser finances the entire purchase price over 30 years at 13 percent. The original cost of $1 million was being depreciated over 40 years (straight line) to a salvage value of $100,000. There was no existing debt at the time of acquisition. The purchaser depreciates the acquisition price over 40 years to a salvage value of $150,000.

	HCFA's COMPUTATION (In Thousands)			OIG's COMPUTATION (In Thousands)		
	FY 85	FY 86	FY 87	FY 85	FY 86	FY 87
CURRENT LAW						
Depreciation	$ 34	$ 34	$ 34	$ 38	$ 38	$ 38
Interest	195	194	194	195	194	194
Return on Equity	--	1	1	--	1	1
Total	$ 229	$ 229	$ 229	$233	$233	$ 233
PROPOSED LAW						
Depreciation	$ 22	$ 22	$ 22	$ 19	$ 19	$ 19
Interest	101	100	100	101	100	100
Return on Equity	--	1	1	--	1	1
Total	$ 123	$ 123	$ 123	$120	$120	$ 120
Capital cost savings						
1st year	$ 106	$ 106	$ 106	$113	$113	$ 113
2nd year		106	106		113	113
3rd year			106			113
Annual savings assuming a similar transaction takes place each year	$ 106	$ 212	$ 318	$113	$226	$ 339
Gain Recovery	(225)	(225)	(225)	124	124	124
Cost savings (loss)	$(119)	$(13)	$ 93	$237	$350	$ 463
Cumulative 3-year effect--Cost savings (loss)			$(39)			$1,050

HCFA's ILLUSTRATION #3

Sale Description

A hospital with a book value of $893,000 is purchased on October 1, 1984, for $1.2 million. The purchaser finances $1 million over 25 years at 12 percent. The remaining $200,000 of the purchase price is financed by equity capital. The original cost of $1 million was being depreciated over 30 years (straight line) to a salvage value of $200,000. There was no existing debt at the time of acquisition. The purchaser depreciates the acquisition price over 30 years (straight line) to a salvage value of $240,000.

	HCFA's COMPUTATION			OIG's COMPUTATION		
	FY 85	FY 86	FY 87	FY 85	FY 86	FY 87
		(In Thousands)			(In Thousands)	
CURRENT LAW						
Depreciation	$ 32	$ 32	$ 32	$ 40	$ 40	$ 40
Interest	120	119	118	120	119	118
Return on Equity	22	23	23	22	23	23
Total	$ 174	$ 174	$ 174	$182	$182	$181
PROPOSED LAW						
Depreciation	$ 27	$ 27	$ 27	$ 30	$ 30	$ 30
Interest	83	82	82	83	82	82
Return on Equity	22	23	24	22	23	24
Total	$ 132	$ 132	$ 133	$135	$135	$136
Capital cost savings						
1st year	$ 42	$ 42	$ 41	$ 47	$ 47	$ 45
2nd year		42	42		47	47
3rd year			42			47
Annual savings assuming a similar transaction takes place each year	$ 42	$ 84	$ 125	$ 47	$ 94	$139
Gain Recovery	(107)	(107)	(107)	59	59	59
Cost savings (loss)	$(65)	$(23)	$ 18	$106	$153	$198
Cumulative 3-year effect-- Cost savings (loss)			$(70)			$457

ATTACHMENT 3
Page 1 of 10

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General

Memorandum

Date JUL 9 1984

From Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum - Areas for Consideration in Developing Recommendations for Reimbursing Hospital Capital Costs Under the Medicare Prospective Payment System (ACN 07-42019)

To Robert B. Helms, Ph.D.
Acting Assistant Secretary
for Planning and Evaluation

In September 1983, we sent you a copy of our preliminary report entitled "Limiting the Depreciation Base When Medical Facilities are Sold Would Substantially Reduce Capital Cost Increases to the Medicare and Medicaid Programs" (ACN 07-32006). In your response and in the course of the subsequent meeting with your staff, we were asked to advise you of any data or findings developed as a result of our further review in this area.

For a number of reasons, our review has not progressed as well as we intended. For one thing, we were asked to testify in March 1984 before the Subcommittees on Health and Oversight of the House of Representatives Committee on Ways and Means on the effect of hospital mergers and acquisitions on capital costs as they related to the Medicare program. Also, we found that the process of developing and gathering data relating to capital costs to be slower and more tedious than originally anticipated. However, in light of the Secretary's mandate to respond to the Congress by the end of fiscal year 1984 on recommended ways to incorporate capital costs into Medicare prospective payment system, we wanted to provide for your consideration a summary updating the information in our preliminary report and some concerns we have regarding the treatment of return on equity capital.

Briefly, our review of capital costs to date has shown that:

-- Hospital mergers and acquisitions have been substantial since the implementation of the Medicare program -- and especially since 1978. Many hospitals have been sold twice and some as many as four times in the last 15 years.

-- Many hospitals were sold at substantial gains. In fact, the selling prices often exceeded the sellers original acquisition cost including improvements.

- Hospital sales and resales have resulted in significant cost increases to the Medicare program without a commensurate change in the quality of facilities or the quantity of services.

- Present Medicare reimbursement policies have not effectively restricted capital cost increases. In fact, the policies may even encourage growth in capital costs.

- Medicare regulations and HCFA's implementing instructions do not provide intermediaries sufficient guidance in establishing the cost basis of assets after sale. Our review of seven hospital sales showed that the assets were overvalued 30 percent, or $27 million.

- Salvage values for depreciation purposes were not always established after hospitals were sold. Consequently, a portion of the $2 billion in annual depreciation costs Medicare reimburses providers may be unnecessary.

The Deficit Reduction Act of 1984 (H.R. 4170) addresses the revaluation of assets problem discussed above and in our September 1983 preliminary report. This legislation requires that, on sale of hospitals or skilled nursing facilities, the valuation of assets after a change of ownership shall be limited to the allowable acquisition cost to the seller or buyer, whichever is less.

A new issue, not previously brought to your attention, concerns whether the Medicare program should continue to reimburse proprietary providers for return on equity capital. Currently, the Medicare program is reimbursing proprietary hospitals about $200 million annually for return on equity capital. In our opinion, these payments appear unwarranted because providers, and in particular proprietary providers, can realize profits as a result of the recently implemented Medicare prospective payment system. Therefore, prospective payments of capital costs should not include amounts for return on equity capital.

More details relating to these matters are included in the attachment to this memorandum. Also, if you desire, members of my staff are available to discuss any of these matters with your staff. To the extent feasible, we also would be willing to furnish or develop additional information on areas which may be of interest to you. In any case, we would appreciate receiving your written comments on our return on equity capital position within 30 days from the date of this memorandum.

Attachment

SUMMARY OF
REVIEW RESULTS OF SELECTED
ASPECTS RELATING TO CAPITAL COSTS

Capital costs consist primarily of depreciation and interest expense. Other items such as insurance and, in the case of proprietary providers, real estate taxes and return-on-equity capital are also classified as capital costs. Currently, Medicare reimburses capital costs on a cost basis. Capital costs relate to buildings as well as building service equipment (installed or fixed equipment such as elevators, boilers, air conditioning equipment, etc.) and movable equipment (beds, chairs, etc.). When hospitals are sold at more than book value (undepreciated cost at the time of sale) capital costs and, consequently, the costs to the Medicare program increase.

MERGERS AND ACQUISITIONS

Of the nation's approximate 6,900 hospitals, at least 1,035 are owned, leased, or managed by proprietary chain organizations. Total acquisitions were not readily identifiable; however, we did identify acquisition of at least 518 hospitals by six major chain organizations during the years 1967 through 1983. About 68 percent or 352 acquisitions occurred since 1978.

Numerous hospitals were sold more than once during the period. Also, many of the acquisitions involved purchases of smaller chains by larger chains. In some instances, a hospital was acquired by the same chain more than once. For example, a hospital owned by chain A was sold to chain B in 1972. Chain A subsequently acquired the hospital from chain B in 1981 and sold the hospital to chain C in 1982.

Effect of Mergers and Acquisitions

Our review indicated that most sales resulted in substantial gains to the sellers. For example, sales of proprietary owned hospitals during the period 1979 to 1981 at two Medicare intermediaries showed that the average selling prices exceeded the sellers' average undepreciated cost by a considerable amount--from 91 to 171 percent. Gains on individual hospitals ranged from $744,000 to $15.9 million. Two hospitals were sold twice during this period. One hospital, with an undepreciated value of $402,500, was sold in 1980 for $1.31 million--a gain of about $908,000. About 9 months later the hospital was sold again for $2.5 million--a gain of about $1.2 million.

Although the above increases are dramatic, they do not show the full effect higher asset values have on the Medicare program. This is because higher asset values not only effect the amounts charged for annual depreciation but the financing charges associated with higher values are increased as well--interest costs if the funds were borrowed and return-on-equity if the funds were invested.

Our detailed review of two hospital sales illustrates the full effect revaluation of assets after sale had on Medicare program costs. At one hospital capital costs per patient day increased from $32.81 to $102.32, or 212 percent, after sale while at the other hospital capital costs per patient day increased from $31.79 to $115.08, or 262 percent, after sale. Total Medicare costs at the two hospitals increased $5.3 million and $1.5 million respectively after sale. And, most of the increases--over 70 percent--resulted from increased capital costs.

EFFECTIVENESS OF MEDICARE REIMBURSEMENT PRINCIPLES DEALING WITH CAPITAL COSTS

Medicare regulations contain several provisions which address the sale of hospitals. One provision requires that when assets (buildings and equipment) are sold, intermediaries are to limit the new cost basis to the lower of the selling price, fair market value, or current reproduction cost adjusted for straight-line depreciation to time of purchase. Current reproduction cost is defined as the cost at current prices, in a particular locality or market place, of reproducing the asset in kind. Acquisition cost in excess of the above limitation is considered goodwill and reimbursement for related capital costs is unallowable.

Although the regulations require specific action on the part of intermediaries, HCFA instructions provide little guidance on how the regulations are to be applied. That is, should intermediaries independently ensure that the selling price does not materially exceed the current reproduction cost of the assets sold by obtaining an appraisal or by applying a construction price index? Consequently, intermediaries rely on appraisals obtained by the buyers or, if no appraisals are made, they rely on the sales agreement to establish the cost basis of assets after sale. Our review showed that appraisals were generally obtained after the sale or after the sales price had been agreed to and were usually obtained to allocate the purchase price to various classes of assets acquired. Acceptance of these appraisals or a sales agreement where an appraisal was not obtained without independent evaluation does not provide assurance that the selling price did not exceed the depreciated current reproduction costs. As a result, a portion of the buyer's cost basis may be unallowable or at least questionable for Medicare reimbursement.

The significance of this problem is illustrated by our review of seven hospital sales. For these sales, the appraised values exceeded depreciated reproduction costs by about $27 million, or 30 percent. The appraised values were higher because:

- Four appraisals used current hospital square feet requirements rather than the actual square footage of purchased hospitals to compute reproduction costs. This increased the value of the hospitals $16 million--17 to 39 percent per hospital. Other appraisals used actual square feet to compute reproduction costs. Appraisals from one company used actual square feet in one instance and current hospital requirements in others.
- Five appraisals used a 50-year life for buildings and building service equipment to determine depreciated reproduction costs. The 50-year life was used instead of the lesser life previously used or allowed for Medicare purposes. This increased the value of the hospitals from 7 to 15 percent. Other appraisals used 40-year lives or less to depreciate building service equipment.
- One appraisal was revised to transfer 50 percent of the building service equipment value to the cost of the building. Since the depreciable life is longer for buildings, the combined cost basis of the building and building service equipment was increased by 6 percent.
- One appraisal increased the value of a hospital by $1.4 million, or about 9 percent, on the basis that the buyer had higher quality construction standards than that of the facility purchased.

Using sales agreements to establish the buyer's asset cost basis may result in overvalued assets, as well. For example, we noted one instance where a hospital with an undepreciated value of about $402,500 sold for $1.31 million--a gain of about $908,000, or 226 percent. About 9 months later, the hospital sold again for $2.5 million--a gain of about $1.2 million, or 91 percent.

In addition, Medicare regulations and guidelines state that salvage values, if any, should be considered in computing straight-line depreciation. Salvage value is the estimated amount expected to be realized upon the sale or other disposition of a depreciable asset when it is no longer useful to the provider. Medicare's Provider Reimbursement Manual states that the amount is ordinarily estimated at the time of acquisition and is deducted from the cost of the depreciable property to arrive at the basis for depreciation.

Our review of sales, however, showed that buyers or intermediaries were not reducing the depreciable base of assets for salvage value. Also, the GAO, as a result of a recent review of a major hospital acquisition involving 54 hospitals, found that the buyer did not assign salvage values to the depreciable assets acquired. The buyer stated that it was common practice in the hospital industry not to assign salvage values and to compute depreciation without regard to this component.

Depreciation costs currently reimbursed by the Medicare program are about $2 billion annually. If asset costs are not reduced for salvage value, depreciation costs may be considerably higher than necessary. We believe that most depreciable assets would have a salvage value. In fact, as stated previously, the salvage value of buildings and building service equipment for those sales we reviewed generally exceeded the original costs.

RETURN ON EQUITY CAPITAL

As you know, the Department implemented a new system--referred to as the prospective payment system--for reimbursing hospitals for Medicare operating costs effective October 1, 1983. The prospective payment system is not based on historical costs. Rather, hospitals are reimbursed a predetermined amount for each patient based on the medical condition treated. The prospective payment system does not include capital costs (primarily depreciation and interest expense) and return on equity capital (REC) which are reimbursed on a cost basis.

The prospective payment system for operating costs is an attempt to obtain services for Medicare patients on a fee for service basis instead of a cost of service basis. The system allows hospitals to realize a "profit" by keeping operating costs at a level lower than the predetermined amount. Since this system allows hospitals to earn a profit through efficient operations, a separate cost reimbursement payment for REC appears unnecessary and, in fact, would represent a potentially redundant payment.

Furthermore, payments to proprietary hospitals under the prospective payment system may result in windfall profits. We analyzed the operating cost data for all hospitals (referred to as the 1981 Section 223 tapes) which was used by HCFA to develop the prospective payments to hospitals. As shown below, this data indicates that the average operating costs for proprietary hospitals is considerably lower than the average operating cost for all hospitals.

	Average Hospital Operating Costs		Difference	
	All Hospitals	Proprietary	Amount	Percent
Per Bed	$85,600	$70,500	$15,100	17.6
Per Discharge	$ 2,200	$ 1,440	$ 760	34.5
Per Inpatient Day	$ 320	$ 290	$ 30	9.4

Because proprietary hospitals have lower average operating costs, they have the potential to realize a profit under the Medicare prospective payment system without further improvements or efficiencies in their operations. For this reason alone REC payments appear unnecessary.

As the national rates are phased in under the prospective payment system, continuing REC payments appears, at best, questionable. Accordingly, we believe that REC payments should not be considered in developing a payment system for hospital capital costs in the future. Elimination of payment to proprietary hospitals for REC would save about $200 million annually.

ATTACHMENT 4
Page 1 of 8

DEC 13 1984

Richard P. Kusserow
Inspector General

OIG Draft Audit Report - Closing Loophole on Hospital Interest Income

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Attached for your information is a draft audit report discussing a Medicare reimbursement exception or loophole involving interest income earned on funded depreciation by Medicare providers of service.

Under Medicare cost reimbursement principles, providers are generally required to offset interest income against interest expenses in their Medicare cost reports. An exception, however, is permitted for interest income on funded depreciation. This income is not a required offset, a feature intended to encourage providers to set aside funds for future capital needs.

Our analysis indicates this loophole is no longer appropriate and its closure would save an estimated $4.7 billion under Medicare and Medicaid over the next 5 years. If future prospective payments of capital costs are based on historical Medicare costs, they should also be reduced to compensate for the increased interest charged to Medicare, caused by the funded depreciation loophole.

We would be pleased to discuss our report with you or your staff, should you want additional information. Also, we would appreciate receiving HCFA's comments on our draft report by December 28, 1984.

Since ASPE has the lead on Medicare capital cost studies, a copy of our draft report is also being forwarded to them for review and comment.

Attachment

cc:
OIG/ES
Reading File
Control File
✓Subject File-388
OA/HCFAD:LKSimmons:TRV:11/30/84:934-3911
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December 13, 1984

Larry K. Simmons, Director
Health Care Financing Audit Division

OIG Draft Report - Closing Loophole on Hospital Interest Income

Patricia Haskins
Audit Liaison
Health Care Financing Administration

Attached are five copies of our preliminary audit report on closing loophole on hospital interest income. We would appreciate review of the draft by appropriate HCFA staff for comment. Any comments should be forwarded to our office by December 28, 1984.

If you have any questions please call me.

Attachments
cc:
Region IX
Control File
Reading File
✓Subject File
LSimmons/ib

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CLOSING LOOPHOLE
ON
HOSPITAL INTEREST INCOME

DEPARTMENT OF HEALTH & HUMAN SERVICES-USA

NOTICE

"This draft of a proposed Office of Audit report is being made available for review and comment by officials having management responsibilities concerning the matters presented. This draft report is not to be considered final as it is subject to further review and revision. Please adequately safeguard this document against unauthorized use."

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

DRAFT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date

From Richard P. Kusserow
Inspector General

Subject OIG Draft Report--Closing Loophole on Hospital Interest Income

To Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

HCFA could save Medicare and Medicaid about $4.7 billion over the next 5 years by closing a loophole on the accounting treatment of interest income earned by hospitals.

To ensure that interest costs paid by Medicare are necessary and reasonable, providers are generally required to reduce interest expenses claimed for reimbursement by interest earnings. An exception to this rule, however, is permitted for interest earned on "funded" depreciation. The exception, which was created to encourage providers to set aside funds for future capital needs, is not warranted for hospitals.

Using Medicare trust funds to subsidize future capital needs of the hospital industry is not appropriate, given that:

- There is a national surplus of hospital beds.
- No shortage of beds is predicted in the near future.
- Medicare is paying interest and depreciation for buildings currently being used in the program.
- Medicare is running out of money to pay for needed services to beneficiaries.

We are recommending that HCFA close the interest income loophole by (i) requiring that interest earnings on funded depreciation be offset against interest costs claimed by hospitals and (ii) reducing any prospective payment allowances developed for hospital interest expenses accordingly.

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Background

As a general and longstanding policy, the Federal government does not help private parties finance their operations by sharing in their borrowing costs. Medicare is an exception to this policy.

A Senate report accompanying the passage of the initial Medicare legislation indicated that Congress intended for Medicare to share in the interest expenses incurred by providers:

> "In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest or capital indebtedness (Senate Report 404, 89th Congress, 1st Session, 1965, p.36)."

In implementing the intent of Congress, Medicare regulations recognize necessary and proper interest as an allowable cost (42 CFR 405.419). In order to assure that Medicare pays for only necessary interest costs, the program requires providers to offset interest income against interest expenses. Medicare regulations do, however, provide an exception to reducing interest costs by interest income. Interest earned on money saved for future capital needs (funded depreciation) need not be offset against interest expenses.

Because many states follow Medicare rules in paying hospital interest costs, this policy often applies to Medicaid as well.

How Hospitals Use Loophole

Here is an example of how a California hospital was able to take advantage of the interest loophole. Last year the hospital had interest expenses of about $548,000 and interest income on investments of approximately $344,000. Under Medicare rules, the interest expenses would usually be reduced by the interest earnings, resulting in net borrowing costs of $204,000 ($548,000 less $344,000). The offset would thereby insure that Medicare did not pay for interest expenses to the extent the provider already had funds on hand earning interest income.

This hospital, though, had set aside nearly $2.5 million for possible future capital needs, earning $283,000 in interest.

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The money set aside was classified as funded depreciation and the interest earned was not subject to offset. Because of the loophole, only $61,000 of the hospital's interest income was offset against interest expenses, and the hosptial's interest costs for Medicare reimbursement purposes were $487,000 ($548,000 less $61,000). If the entire amount of interest income had been offset, only $204,000 would have been subject to Medicare reimbursement, or $283,000 less than that actually claimed by the hospital.

Justification for Policy

Favorable treatment was given to interest earned on funded depreciation to encourage providers to set aside funds for future capital needs:

> ". . . It is the function of payment of depreciation to provide funds which make it possible to maintain the assets and preserve the capital employed in the production of services . . . . Moreover, recognition of this cost is necessary to maintain productive capacity for the future. An incentive for funding of depreciation is provided in these principles by the provision that investment income on funded depreciation is not treated as a reduction of allowable interest expense . . . (42 CFR 405.418)."

This incentive is not justified for hospitals, given the national surplus of hospital beds. According to the President's Private Sector Survey on Cost Control (the Grace Commission study), there are somewhere between 68,000 to 264,000 excess hospital beds nationally, generating from $2.3 billion to $8.8 billion in unnecessary medical costs each year.

Limited Trust Fund Resources

The Medicare trust fund was established to help defray medical costs incurred by the elderly. Using limited trust fund resources to subsidize capital formation by hospitals is inappropriate.

According to HCFA's actuaries, the Medicare trust fund may well be exhausted in the 1990s. In view of this impending crisis, HCFA should stop these subsidies aimed at maintaining hospital bed capacity for the future. In the unlikely event that there is a future shortage of hospital beds (no such shortages are now projected), HCFA could later request separate appropriations from Congress to encourage hospital capital expansion.

Potential Savings

Closing the loophole on treatment of interest earned on funded depreciation would produce significant Medicare and Medicaid

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savings. HCFA contracted for a study1/ to determine, among other things, the potential savings to Medicare if interest earned on funded depreciation was offset against interest expenses. The contractor analyzed a sample of 511 hospitals and estimated that the potential savings for just those hospitals reviewed was probably between $41.5 million and $50 million a year, or about one-half of all interest costs claimed by these hospitals.

HCFA does not have data on the total interest expenses incurred by the 6,700 hospitals participating in Medicare. However, the Assistant Secretary for Planning and Evaluation recently determined the amount of Medicare interest expenses for inpatient services that were claimed by about 5,500 hospitals. Based on this determination, we estimate Medicare payments for interest costs on inpatient and outpatient services for all 6,700 hospitals to be about $1.2 billion in 1984. Assuming that Medicare payments to hospitals for interest costs could be reduced by about one-half, as indicated in the HCFA contracted study described above, we estimate that closing the loophole could save Medicare about $600 million a year.

Because many states follow Medicare rules for paying hospital interest costs, significant savings are also possible under the Medicaid program if the current policy was changed. We estimate that Medicaid would save an additional $170 million annually, consisting of Federal savings of about $94 million and savings to the states of about $76 million.

Thus, the total Medicare and Medicaid savings would be about $770 million a year. Over a 5 year period, the savings, including $850 million in compound interest, would amount to about $4.7 billion.

Prospective Payment Rates

Medicare is expected to begin paying for hospital interest costs through prospective payment rates in October 1986, rather than under the present method of cost reimbursement. In setting the rates, HCFA should reduce any prospective allowances for hospital interest expenses by offsetting interest earned on funded depreciation. Such a reduction will help assure that Medicare pays only for necessary borrowing costs.

Impact on Hospitals

The HCFA contracted study indicated that about 80 percent of the savings would come from hospitals (mostly nonprofits) in urban areas. Since surplus hospital beds are primarily concentrated in urban areas, there is even less justification for hospitals in these areas receiving subsidies, via the interest exclusion exception, for future capital needs.

1/ Analysis of Interest Income on Funded Depreciation, Applied Management Sciences, G-147.52, November 30, 1982.

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Requiring hospitals to offset interest earned on funded depreciation should not cause undue financial hardship. Hospitals have, under their control and available for use, the interest earnings on their funded depreciation.

What is more, only relatively affluent hospitals would be affected if the loophole was closed. Financially strapped hospitals cannot afford to set aside funds for possible future uses and are unable to take advantage of the special treatment given to interest earned on funded depreciation.

HCFA's Authority to Change Policy

In our review of the Medicare law and accompanying Congressional reports, we have found nothing that requires HCFA to provide an exception to Medicare's interest offset rule for funded depreciation. It appears, therefore, that HCFA has the administrative authority to change the current policy. If, however, HCFA were to determine that it does not have sufficient administrative authority to make the change, it should seek legislative authority to do so.

Conclusion

The Medicare rule requiring interest expenses claimed by providers to be reduced by interest income is a good one: it helps assure that Medicare pays for only necessary and reasonable interest costs. The exception for interest earned on funded depreciation, though, is not a good rule. It was developed to encourage providers to set aside funds for future capital needs. The exception is inappropriate, given the surplus of hospital beds, lack of predicted bed shortages in the near future, Medicare payments for interest and depreciation on hospital buildings currently in use, and the impending bankruptcy of the Medicare trust funds. HCFA needs to close this loophole which subsidizes possible future capital requirements of the hospital industry with Medicare trust funds.

Recommendations

We recommend that HCFA, by implementing a rule change, or by seeking legislation if necessary:

1. Require that interest earnings on funded depreciation be offset against interest costs claimed by hospitals under Medicare and Medicaid.

2. Reduce any prospective payment allowances developed for hospital interest expenses by earnings on funded depreciation.

I would appreciate receiving your comments within 30 days of the date of this memorandum.

DEC 20 1984

Richard P. Kusserow
Inspector General

Priority Audit Memorandum - Closing Another Loophole on Hospital Interest Income: Interest on Donated Funds (ACN 09-52002)

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

On December 13, 1984, we furnished to HCFA for review and comment our draft audit report on a Medicare reimbursement loophole involving interest earned by Hospitals on their funded depreciation. This interest income is not a required offset against their interest expenses, a reimbursement exception or loophole we estimate is costing Medicare and Medicaid about $770 million annually. We are now studying a second loophole which permits providers to not offset against expenses interest income on donated funds. Closing this loophole would produce additional savings, also potentially involving millions.

Medicare rules for paying interest costs, which many States use for Medicaid purposes, generally require hospitals to reduce interest expenses claimed for reimbursement by interest earnings (42 CFR 405.419). This policy helps ensure that the Government health programs do not pay for unnecessary borrowing costs. Interest expenses usually will not be reimbursed to the extent a hospital already has funds on hand and earning interest.

An exception to this policy, however, is allowed for interest earnings on donated funds. This exception was originally tied to Medicare's treatment of unrestricted gifts in the days of cost reimbursement, although it now applies to both restricted and unrestricted funds. In order not to discourage donations to hospitals, unrestricted gifts and income earned from these gifts were not offset against operating costs. Gifts restricted by donors for specific purposes, such as emergency room services, were offset in the past but are not now under the prospective payment system.

While there may be merit to the special treatment given to the donations themselves, there is no apparent justification for the interest income loophole. Offsetting interest earned on donations against interest expenses should not discourage private gifts to hospitals because the donations themselves are not offset against operating costs. More important, Medicare should only pay for necessary interest costs. If a hospital has funds on hand earning interest income, and still elects to borrow funds and pay interest, Medicare should share in the interest expense only to the extent that it exceeds the interest income. However, under current reimbursement provisions, Medicare is paying for interest expense but not sharing in interest income. This is clearly inequitable to Medicare.

There are two other reasons why special treatment should not be given to interest income from donated funds. First, the policy disproportionately benefits relatively affluent hospitals that can afford to invest donated funds rather than using the money for current needs. Second, the Government already subsidizes donations made to nonprofit hospitals by allowing the donors to deduct charitable contributions on their Federal income tax returns.

The Medicare and Medicaid policy of not offsetting interest income against expenses, at least as it relates to unrestricted endowment funds, was endorsed by Congress in the Medicare and Medicaid Amendments of 1980 (42 USC 1320b-4). As a result, using interest earnings on unrestricted gifts and grants to reduce Medicare and Medicaid interest costs would require Congressional approval. For restricted funds, Congress left the policy up to the discretion of HCFA. Thus, HCFA has the administrative authority to change its policy and require interest earned on restricted donations to be offset against interest expenses.

We are considering recommendations that HCFA (i) seek legislative authority to use interest earned on unrestricted donations to reduce Medicare and Medicaid interest costs, (ii) change its current policy with respect to restricted donations to require offset of interest income against interest costs claimed, and (iii) reduce any prospective payment allowances developed for hospital interest expenses by interest earned on donated funds.

Also, we are attempting to determine the savings that could be achieved from our proposal. Because nonprofit hospitals are the recipients of substantial donations, the savings would probably be significant. In this connection, if HCFA has information on the potential amount involved, we would appreciate receiving this data and HCFA's early view on the recommendations we are considering.

Medicare Allowance of Depreciation on Assets Financed with Federal Funds

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

Audit Control No. 09-52020

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date DEC 27 1984

From Richard P. Kusserow Bryan Mitchell
Inspector General

Subject OIG Audit Report - Medicare Allowance of Depreciation on Assets Financed with Federal Funds (ACN 09-52020)

To Carolyne K. Davis, Ph.D
Administrator
Health Care Financing Administration

The attached report examines Medicare's policy of paying providers, especially hospitals, the costs of depreciation on assets financed with Hill-Burton grants or other Federal funds. We believe the policy is resulting in duplicative Federal payments for the same assets - once through a construction grant and secondly as Federal payments of depreciation as a cost of Medicare and Medicaid patient care.

The current Medicare policy on this matter is inconsistent with the Department's policy on other grant programs and contracts - including Medicare's contracts with the intermediaries and carriers which administer Medicare on the local level. The original rationale behind the present policy - maintaining provider capacity for the future - has little merit today, given the surplus of hospital beds and the projected deficits facing both the General Fund and the Medicare Trust Funds.

We are recommending that HCFA discontinue Medicare and Medicaid payments of depreciation on assets financed with Hill-Burton or other Federal funds, and that such depreciation be excluded from any system of prospective payment for hospital capital costs that may be adopted. A one-time savings of about $720 million spread over a number of future years is possible.

Your staff expressed several concerns with our recommendations, but fundamentally thought the question ought to be addressed as part of the Congressionally-mandated study of how and the extent to which capital costs (including depreciation) ought to be paid as part of the hospital inpatient Prospective Payment System. They believe that it would be premature to eliminate depreciation on these assets before the Congress has decided how it wants to handle Medicare payments for capital. We believe that view is reasonable and consistent with the intent of our recommendations.

Please advise us within the next 60 days, of the progress being made on the study of prospective payment for hospitals' capital costs and how depreciation on Federally-funded assets is being considered.

Attachments

INTRODUCTION

The Government is paying twice for hundreds of millions of dollars in provider assets: once through direct grants and a second time through Medicare and Medicaid depreciation allowances. HCFA, though, has an opportunity to prevent further double payment -- and save Medicare and Medicaid about $720 million -- by revising the current policy and eliminating depreciation allowances on health facilities financed with Federal funds under the Hill-Burton program.

The current policy which allows providers to claim depreciation on Federally funded property should be stopped not only because it results in the Government paying twice for the same assets, but also because:

- no other HHS program permits grantees or contractors to claim depreciation or use allowances on property purchased with Federal funds.
- the original rationale behind the policy -- maintaining capacity for the future -- lacks current merit, at least for hospitals, given the present surplus of hospital beds.
- maintaining provider capacity does not appear to be an appropriate use of Medicare trust fund resources, especially in view of the serious financial difficulties currently facing the fund.

According to the Office of General Counsel (OGC), HCFA has the authority to change its policy and corresponding regulations without seeking legislative changes. We are recommending that HCFA prohibit Medicare and Medicaid depreciation allowances on assets financed with Hill-Burton or other Federal funds.

HCFA believes the matter should be resolved as part of the larger issue of how payments for capital costs (including depreciation) ought to be made in connection with the hospital Prospective Payment System.

Background

The Hill-Burton program, authorized by Public Law 79-725, provided Federal grant funds for constructing and modernizing hospitals and other health facilities. From 1946 until 1974, a total of about $4.4 billion in Federal funds was disbursed under that Program. In return for the Hill-Burton grants, providers are to give free care to persons unable to pay.

Hospitals and other providers paricipating in the Medicare program, including those whose assets were financed in whole or part by Hill-Burton grants, have been reimbursed for their reasonable costs of treating Medicare patients. Depreciation on assets used to provide patient care is one such reimbursable cost. Effective October 1, 1983, the law requires that Medicare begin paying for certain inpatient hospital expenses based on prospectively determined rates. However, capital expenses, including depreciation, continue to be paid on a cost reimbursable basis.

Since November 1966, Medicare regulations defining reasonable cost have allowed depreciation on assets financed with Hill-Burton or other Federal funds (42 CFR 405.418). Because most States' medical assistance programs use the Medicare provider cost principles, the Medicaid program has also been paying for depreciation on such Federally funded property.

The purpose of our review was to determine whether the Medicare policy of allowing reimbursement for depreciation on Hill-Burton assets was appropriate. We studied Medicare laws and regulations and Congressional reports. We also held discussions with HCFA and PHS representatives, and solicited comments from the Assistant Secretary for Planning and Evaluation. In addition, we visited four hospitals in Northern California and the Federal records center in San Bruno, California.

DISCUSSION OF FINDING

Conflict With Other HHS Policies

The Medicare policy of allowing depreciation on Hill-Burton assets conflicts with cost principles applicable to other HHS programs. For example, the following criterion for determining allowable cost applies to grants and contracts with nonprofit institutions:

> "Computation of the use allowance and/or depreciation will exclude both the cost or any portion of the cost of grounds, buildings and equipment borne or donated by the Federal government (45 CFR Part 74, Appendix F)."

For determining the allowable costs of contracts with commercial organizations, the following applies:

> "No depreciation, rental, or use charge shall be allowed on property acquired at no cost from the Government by the contractor or by any division, subsidiary, or affiliate of the contractor under a common control (41 CFR 1-15.205.9)"

The Medicare policy of allowing providers to claim reimbursement on Federally financed assets is not even consistent with HCFA's policy on carrier and intermediary cost reimbursement. Again, unlike providers, carriers and intermediaries may not receive a depreciation allowance on Federally financed assets:

> "No depreciation, rental, or use charge will be allowed on property acquired at no cost from the Government by the contractor (Appendix B, 1-80, Medicare Intermediaries and Carriers Manuals)."

In contrast to the Medicare policy for providers, these contractor/grantee cost principles are aimed at avoiding reimbursing currently for the use of assets previously purchased with Federal funds.

To the extent that health facilities were originally financed with Hill-Burton funds, they were paid for by the Federal government. To the extent that the Government has paid and is continuing to pay for depreciation of these assets through the Medicare (and Medicaid) programs, to that extent does it bear the costs of those assets a second time.

Justification for Allowance

The Medicare regulations contain the following rationale in support of paying depreciation on Federally financed assets:

> "It is the function of depreciation to provide funds which make it possible to maintain the assets and preserve the capital employed in the production of services ... recognition of this cost is necessary to maintain productive capacity for the future (42 CFR 405.418)."

This rationale, developed in 1966, may not have as much merit today at least with respect to hospitals.

The President's Private Sector Survey on Cost Control (the Grace Commission) estimated that nationally there are from 68,000 to 264,000 excess hospital beds, costing from $2.3 billion to $8.8 billion a year. The Grace Commission concluded that Medicare could save about $939 million in three years if excess hospital capacity were reduced:

> "After decades of supporting an increase in hospital capacity to ensure availability of care to all citizens, the Federal Government now has an incentive to reduce excess capacity in order to contain rising costs and promote system-wide efficiency (Grace Commission Report Recommendations, Report on PHS and HCFA, HHS-HCFA-5, Excess Hospital Capcity, p. 67)."

Potential Savings

About $4.4 billion in Federal funds was disbursed under the Hill-Burton program between 1946 and 1974 when that grant program was discontinued. The undepreciated balance of assets acquired by providers under the Hill-Burton program was about $1.8 billion as of December 31, 1983, according to the Public Health Service estimates. With Medicare and Medicaid currently paying about 40 percent of all hospital bills, we roughly estimate that the elimination of depreciation on Hill-Burton assets could save Medicare and Medicaid a total of about $720 million. Additional savings might be achieved by the elimination of depreciation allowances on assets financed under other Federal programs.

Impact on Average Facility

About 6,700 facilities received Federal funds under the Hill-Burton program. Of these, about 4,000 were hospitals, which received about $4 billion or about 90 percent of the total Hill-Burton grants. Assuming a 40 year useful life for each facility, the annual depreciation expense would average only about $25,000 per hospital. The portion paid by Medicare/Medicaid would be much less. For example, Medicare and Medicaid patients account for about 40 percent of the average hospital utilization. This translates into an average of about $10,000 per hospital per year of Hill-Burton financed assets paid for again by Federal/State health programs.

HCFA's Authority to Change Policy

We requested a legal opinion from the Office of General Counsel (OGC) as to whether HCFA has the authority under present law to to amend the regulations to prohibit depreciation on Federally financed assets under Medicare and Medicaid. In OGC's opinion HCFA does have that authority, provided that, in doing so, all procedures under the Administrative Procedure Act (5 USC 551 et seq.) are followed. OGC informed us that it found nothing in the Social Security Act nor its legislative history that specifically directed HCFA to permit Medicare or Medicaid depreciation on property purchased with Hill-Burton funds.

Capital Costs and the Hospital Prospective Payment System

The Social Security Amendments of 1983 established a Medicare prospective payment system for inpatient hospital services. The system is being phased-in over three years starting with each hospital's first cost reporting period beginning on or after October 1, 1983. It will be fully implemented in the fourth year. The system replaces the previous cost reimbursement system for hospital inpatient services with prospectively established diagnosis-related rates for each hospital stay. However, payments for hospitals' capital expenses - including asset depreciation - are specifically excluded from the prospective rates until October 1, 1986. At least until then, capital expenses are being reimbursed, as previously, on a reasonable cost basis. The Law also provides that the Secretary is to review the methods by which capital, including depreciation, can be incorporated into the prospective payment system. We believe HCFA should exclude hospitals' depreciation on Federally funded assets from any proposals for the payment of hospital capital costs through the prospective payment system.

Conclusion

Medicare and Medicaid payment of depreciation on assets paid for with Federal funds is inconsistent with the cost principles used by all other HHS programs. It also results in double Federal participation in the cost of those health facilities -- once as a grantor of funds for the acquisition of capital assets, and a second time as a purchaser of asset depreciation as one cost of medical care furnished to Medicare and Medicaid patients. Given the projected deficits facing both the General Fund and the Medicare Trust Funds, and the current surplus of hospital beds, we don't believe these duplicative payments can any longer be justified by an assumed Medicare responsibility for the maintenance of hospital bed-capacity in this country.

RECOMMENDATIONS

In an earlier draft version of this report, we recommended that HCFA:

- prohibit Medicare and Medicaid depreciation allowances on assets financed with Hill-Burton or other Federal funds.
- assure that Hill-Burton or other Federally funded depreciation is not included in prospective reimbursement rates developed for capital-related expenses.

Discussion of HCFA's Response

In responding to the draft report, HCFA staff did not agree with elimination of a depreciation allowance on health facilities financed with Hill-Burton funds. (HCFA's reply is included in its entirety as an Appendix to this report.) HCFA expressed a number of concerns they had with our recommendations, but fundamentally thought the question ought to be addressed as part of the larger issue now being studied of how and the extent to which capital costs ought to be paid in connection with the recently implemented hospital Prospective Payment System. The study is mandated by Law and HCFA believes it would be premature to eliminate the recognition of depreciation for Hill-Burton providers before Congress has decided how it wants to handle payments for capital. HCFA said that it will review the amount of depreciation to be recognized as part of the base rates in any capital prospective payment method for Medicare.

We believe HCFA could begin to realize savings sooner if it acted now to disallow depreciation on Hill-Burton assets. However, HCFA's intended course of action is reasonable and consistent with the intent of our recommendations.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 18 1984

From Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Subject Office of Inspector General (OIG) Draft Report - Medicare Allowance for Depreciation on Assets Financed with Federal Funds - (ACN 09-42020)

To The Inspector General
Office of the Secretary

We have reviewed your draft audit report which recommends the elimination of the depreciation allowance on health facilities financed with Hill-Burton funds. We do not agree with the recommendations at this time. We feel it would be premature to eliminate the recognition of depreciation for Hill-Burton providers before Congress has decided how to include payments for capital in the Prospective Payment System (PPS). We would like to offer the following thoughts on this subject.

The payment of depreciation by Medicare and Medicaid for assets financed with Hill-Burton funds played a significant role in the formation of capital and the overall financial structure of providers. These providers have incurred financial commitments on the basis of the cash flow generated from Medicare and Medicaid depreciation payments for the Hill-Burton assets. Assets obtained under Hill-Burton were not free, but included the obligation of providing "no charge" services, essentially constituting an exchange of assets similar to any other transaction engaged in by providers to acquire health care resources.

The report claims that the Federal government is paying twice for health facility assets purchased with Hill-Burton grant funds because these programs pay depreciation on facilities built with grant funds. We do not agree. The "quid pro quo" for the government's providing Hill-Burton funds was the provision of free care. We believe that this obligation is the "payback" for the grant. Thus, if Medicare were to refuse to pay depreciation, we are in effect not recognizing that the facility is "paying for" the assets purchased with grant money through provision of services. Moreover, if the facility was worth building, we question whether we should not allow the depreciation expense to be recognized as a means to keep it refurbished and up to date like all other facilities.

The draft report states, "no other HHS grantees or contractors are allowed to claim depreciation or use allowance on property purchased with Federal funds." However, this statement does not tell us whether the situations in which this prohibition applies are analogous to Medicare reimbursement. For example, was the non-payment of depreciation a condition at the time the grant was awarded or when the contract was signed? Were the assets to be used entirely for the provision of services paid for by the government? It would seem the relevance of this generalization is questionable given that the Hill-Burton grant program antedates the Medicare program. We feel that the distinction between Medicare and Medicaid paying depreciation on Hill-Burton assets and HHS grantees and contractors being denied depreciation is valid. The rationale supporting payment of depreciation on Hill-Burton assets by Medicare and Medicaid is that providers can maintain productive capacity in an ongoing operation by having the funds necessary to replace the assets. On the other hand, there is no need for grantees or contractors to maintain productive capacity beyond the expiration of the grant or contract.

Also included in the draft report is the recommendation that HCFA assure that Hill-Burton depreciation is not included in prospective payment rates developed for capital-related expenses. Although we will certainly give serious consideration to this recommendation, we anticipate encountering significant problems if the recommendation were to be adopted without giving any consideration to the total capital needs of hospitals previously operating with Hill-Burton assets. At this time, decisions have not been finalized as to whether any portion of capital costs under PPS will be "provider specific". . Accordingly, if no portion of PPS capital costs is "provider specific," but rather solely based on one or more formulae, any attempt to factor the exclusion would not be equitable to all providers because not all providers have received Hill-Burton funds, and of those providers that have purchased assets with Hill-Burton funds, the amount of depreciation on the Hill-Burton assets applicable to each provider varies significantly. We will however review the amount of depreciation to be recognized as part of the base rates in any capital prospective payment method for Medicare.

Any questions you may have on this subject should be directed to Pat Haskins, FTS 934-7484.

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1 3 1985

/s/ Richard P. Kusserow
Richard P. Kusserow
Inspector General

Priority Audit Memorandum - Establishment of a Minimum Salvage Value on Depreciable Assets Could Save the Medicare Program Millions (Audit Control Number 07-52004)

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

The Medicare program reimburses hospitals about $1.6 billion annually for depreciation on buildings and building service equipment. Based on our preliminary findings, we estimate that a significant portion of these payments is unnecessary because most hospitals do not reduce the cost of depreciable assets for salvage value before claiming depreciation, even though the salvage values may be substantial. If hospitals were required to establish a minimum asset salvage value of 10 percent, annual Medicare depreciation costs would be reduced about $160 million.

When determining the amount of depreciation, Medicare regulations and guidelines require that salvage values, if any, should be deducted from the cost of depreciable assets at the time of acquisition. Also, program instructions state that an asset should not be depreciated below its salvage value. Salvage value is the estimated amount expected to be realized upon the sale or other disposition of a depreciable asset when it is no longer useful to the provider.

Statements by intermediary and health care officials indicate that it is the general practice in the hospital industry not to reduce the cost of depreciable assets by salvage value. This practice was noted by the General Accounting Office during a 1983 review of a major hospital acquisition involving 54 hospitals. GAO found that the buyer did not assign salvage values to the depreciable assets acquired. The buyer stated that because it is the general practice of the hospital industry not to assign salvage values to depreciable assets, depreciation is almost always computed without regard to this component.

We evaluated the cost effect of asset salvage values at one major intermediary. This intermediary served 225 hospitals -- 47 non-profit and 178 proprietary -- in 17 States. Our review showed that the cost of the depreciable assets at few hospitals had been reduced for salvage value. Intermediary officials stated that they had no policy requiring salvage values. However, the accounting policies of two proprietary chain corporations discussed the establishment of salvage values. For example, the accounting manual of one corporation stated that "For book purposes, depreciation is calculated on a straight-line basis after providing for a 10 percent salvage value." A review of hospitals owned by this corporation showed that the depreciable assets were not reduced for salvage values, except in one minor instance.

In our opinion, most depreciable assets -- especially buildings and building service equipment -- have salvage values. This was corroborated by our detailed review of 30 hospital disposals during the period 1977 through 1982 at 3 intermediaries. Most of the disposals were sales between proprietary corporations. However, some disposals were sales between non-profit organizations or between non-profit and proprietary organizations. At least one hospital facility was sold for non-health care use. Details relating to these disposals are shown below:

		Total Depreciable Assets		
	Number of Hospitals	Seller's Acquisition Cost	Selling Price (Salvage Value)	Ratio of Selling Price t Seller's Acquisition Cos
		--------(in	Millions)-------	
Selling Price Exceeded Seller's Acquisition Costs	22	$151.5	$241.2	159%
Selling Price Exceeded Seller's Book Value	2	21.0	19.6	93%
Selling Price Less Than Seller's Book Value	6	21.2	8.4	40%
	30	$193.7	$269.2	139%

As shown, most depreciable assets had substantial salvage values. This is evidenced by the high ratio of selling price to acquisition price. For example, for the 24 sales which resulted in gains, the selling price of depreciable assets, in total, exceeded the original acquisition cost for 22 hospitals and was 55 and 95 percent of the original acquisition cost for 2 hospitals. However, none of the depreciable assets had been reduced for salvage values before claiming depreciation.

In only six instances did the sales result in a loss. And, although the depreciable assets were sold at prices below their book values, the selling prices were 24 to 51 percent of the acquisition costs.

When depreciable assets are disposed of, Medicare regulations provide for adjustments to recover overpaid depreciation resulting from understated salvage values. However, as reported to you in a previous Priority Audit Memorandum 1/ the value of the amount recovered -- due to the time value of the money -- would be substantially less than depreciation paid to the providers. In addition, because the Federal Government borrows money to fund its operations, interest costs are incurred for depreciation unnecessarily paid by the Medicare program. For example, at a 10 percent interest rate, interest cost of $1.48 would be incurred for every dollar not recovered for a period of 10 years. Due to the effect of compounding, the cost to the Federal Government would be substantially more if the recovery period was longer.

If our review results are representative of the industry as a whole, the depreciable cost of assets at most hospitals participating in the Medicare program is substantially overstated. Consequently, the depreciation costs currently reimbursed by the Medicare program -- which amount to about $1.6 billion annually for buildings and building service equipment -- are considerably higher than necessary. If providers were required to establish a minimal salvage value of only 10 percent, the Medicare program could reduce expenditures by about $160 million annually as well as realize substantial savings by reducing the associated interest costs. At a 10 percent annual interest rate, the interest cost on $160 million for over 10 years would be $236 million.

Furthermore, when depreciable assets are not reduced for salvage value, reported depreciation overstates the final

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1/ "Need to Limit the Revaluation of Assets After Sale of Hospitals and Nursing Homes" (Audit Control Number 07-42016) issued June 25, 1984.

costs to the Medicare program. This occurs because reported depreciation is not reduced to reflect depreciation recovered when hospitals are sold at a gain. Historical annual depreciation costs, if used in setting prospective payments for capital costs, should be reduced by about $160 million to compensate for the effect of overstated amounts historically claimed.

HCFA should require that a reasonable salvage value by type of depreciable asset be established to eliminate unwarranted depreciation payments. This would not only reduce program expenditures and interest savings to the Federal Government but would reduce unwarranted interest free loans to providers.

Although our review in this area is continuing, we would appreciate your comments within 30 days from the date of this memorandum to assist us in our review.

We are also forwarding a copy of the PAM to ASPE for consideration in the drafting of the Congressionally mandated study of capital costs under PPS.

ATTACHMENT B
Page 1 of 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Memorandu

Date JAN 15 1985

From Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum - Reducing DRG Rates for Capital Costs Could Save Billions (ACN: 07-52008)

To Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Preliminary results of an on-going review of the Medicare prospective payment system (PPS) indicate that approximately $1 billion in capital costs attributable to inpatient hospital services was included in the 1981 cost report data used to calculate the DRG rates for FY 1984. Under PPS, capital costs are reimbursable as a "pass through" on a retroactive cost basis. Including these capital costs in the DRG rates, therefore, duplicated Medicare costs by about $420 million during FY 1984. We estimate that these duplicate costs will increase Medicare payments by about $2.8 billion (see attachment) during the five years beginning October 1, 1985.

The Social Security Amendments of 1983 adopted a prospective payment system for hospital cost reporting periods beginning on or after October 1, 1983. Under this system, predetermined rates are established for inpatient hospital services on a per discharge basis. During the first three years of PPS, the predetermined rates are established through a blending of hospital specific costs and the average cost per Medicare discharge, commonly referred to as the Federal portion. The Federal portion is phased-in at 25 percent per year starting in FY 1984; by FY 1987, the PPS rate will be totally based on the national average cost per discharge. Even though the Federal portion includes most inpatient expenditures, certain costs, such as capital costs, continue to be reimbursed on a retroactive cost basis. To avoid duplication, capital costs had to be excluded by HCFA from the calculated Federal portion of the DRG rates.

HCFA developed procedures to exclude capital costs from the hospitals' 1981 Medicare cost report data used to calculate the DRG rates. We reviewed these procedures to determine whether all capital costs had been properly excluded from the total Medicare inpatient costs prior to computing the Federal

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portion. Our review indicated that these procedures did not exclude certain capital costs allocated through the hospitals' general service cost centers to ancillary services and special care units. This occurred because these unidentified capital costs were commingled with other costs through Medicare cost report allocation procedures. Additionally, HCFA's procedures did not exclude capital costs allocated to emergency room services.

Based on our independent application of HCFA's procedures for excluding capital costs from the 1981 cost report data for 5,631 hospitals, we estimated that $4.2 billion of capital costs was excluded from hospital operating costs for DRG rate setting purposes. For eight of these hospitals, we also determined, through extended auditing procedures not required by HCFA's instructions, the amounts of capital costs allocated to ancillary and emergency room services, and special care units, which were not excluded in formulating the Federal portion of the DRG rate. We estimate, based on this analysis, that about $5.2 billion of capital costs should have been excluded by HCFA, about $1 billion more than the amount excluded under HCFA procedures. This unexcluded amount overstated Medicare's costs used to calculate the Federal portion by about $420 million, which is based on Medicare's utilization being 40 percent of these services.

In setting the hospital specific portion of the 1984 DRG rate for each hospital, intermediaries also had to exclude capital costs from the hospitals' operating costs reported on their 1982 Medicare cost reports. HCFA developed instructions and procedures for intermediaries to use to exclude capital costs. Using the 1982 cost reports for 35 hospitals, we compared the capital costs excluded under HCFA's procedures used for the 1981 cost reports (Federal portion) against amounts excluded under HCFA's procedures used for the 1982 cost reports (hospital specific portion). Our comparison indicated that for the 35 hospitals tested, the instructions for the 1982 cost reports excluded larger amounts of capital costs. We estimate, from this limited test, that the Federal portion of the 1984 DRG rate is overstated by approximately 1.5 percent of total inpatient hospital costs. This further corroborates our conclusion that the Federal portion is overstated by about $420 million for FY 1984.

In FY 1986, HCFA is mandated to recalibrate the DRG weights. We believe that for FY 1986, HCFA should also consider rebasing the DRG rates to correct deficiencies inherent in the present data base. One option HCFA should consider would be to rebase

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the Federal rate using 1982 cost report data. This is important because the DRG rates will be based 75 percent on the Federal portion in FY 1986 and 100 percent thereafter. Using the 1982 cost report data would not only correct deficiencies relating to the capital costs, thereby saving about $2.8 billion, but would also utilize the audited base year cost report data. Additionally, it would be consistent with HCFA's policy of using the best available data to establish future payment rates.

We would appreciate your comments on this matter.

Attachment

cc:
OIG/ES
Felix J. Majka
Bryan B. Mitchell
Richard McGowan
Patti Birge Tyson
C. McClain Haddow
John O'Shaughnessy
Larry D. Morey
James Scott
Kenneth M. Nelson
Joseph Vengrin (4)
Richard L. Mangione
Donald Nicholson
Patricia Haskins
Anna Boyd
Michael Mangano
Gerald Britten
Joseph Piazza
RIGAs
Control File
Reading File
Subject File
GKramer/ib:1/4/85:934-3910

OIG/LS

MAY 13 1985

/s/ Richard P. Kusserow
Richard P. Kusserow
Inspector General

Priority Audit Memorandum - Further Reductions Still Needed in DRG Rates for Capital Costs: Would Save Billions (ACN: 07-52011)

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

As you know, our Priority Audit Memorandum (PAM) dated January 15, 1985 pointed out that all capital costs identifiable in the 1981 hospital cost report data had not been excluded before calculating the Federal portion of the FY 1984 diagnostic related group (DRG) rates. Our audit work has now identified a related second problem involving duplicate reimbursement for capital costs through established DRG rates and pass through amounts. We estimate the impact of this second problem at $966 million in FY 1981. Medicare's share was about $319 million. Over 5 years, these additional Medicare duplicate payments could amount to about $2.25 billion (see Attachment A).

The Social Security Amendments of 1983 adopted a prospective payment system (PPS) for hospital cost reporting periods beginning on or after October 1, 1983. Under this system, predetermined rates are established for inpatient hospital services on a per discharge basis. During the first 3 years of PPS, the predetermined rates are established through a blending of hospital specific costs and the average cost per Medicare discharge, commonly referred to as the Federal portion. The Federal portion is phased-in at 25 percent per year starting in FY 1984; by FY 1987, the PPS rate will be totally based on the national average cost per discharge. Even though the Federal portion includes most inpatient expenditures, certain costs, such as capital costs, continue to be reimbursed on a retrospective basis. To avoid duplication, capital costs had to be excluded from the 1981 hospital cost data HCFA used to calculate the Federal portion of the DRG rates.

We reviewed the audited 1982 or 1983 hospital cost reports for 134 hospitals located in 16 States. These cost reports, unlike the 1981 cost reports which were the basis for the present PPS rates, identified for the first time the full amount of capital costs at these hospitals. Prior to 1982, many hospitals charged certain capital costs such as home office depreciation and interest, equipment depreciation and interest, and lease expenses directly to departmental cost centers and reported the expenses as operating rather than capital costs. (Before PPS there was no need to accurately identify all capital costs or any requirement to separate allocated home costs between operating and capital costs.) As a result, these type capital costs were not excluded from the 1981 cost report data used to calculate the Federal portion of the FY 1984 DRG rates.

The cost report audits of the 134 hospitals identified about $666.3 million in total Medicare inpatient costs -- $67 million of which we estimate was capital costs. However, only about $59.7 million of these costs would have been identified as capital expenditures in the hospitals' 1981 cost reports because of the practices they followed for charging the various cost centers. The balance of about $7.3 million was identified for the first time as capital costs on the audited 1982 or 1983 hospital specific base year cost reports.

We projected the results of the 134 hospitals reviewed to the 5,631 hospitals used to develop the Federal portion of the PPS rates. The additional capital costs identified represent 1.2 percent of the total Medicare inpatient operating costs. We applied the 1.2 percent factor to the 1981 total inpatient operating costs of approximately $80.5 billion for the 5,631 hospitals and determined that the standardized Federal amount of the DRG rates was overstated by approximately $966 million. Medicare's share was about $319 million in FY 1981 (see Attachment B).

To date, the capital cost issues we have brought to HCFA's attention demonstrate that either the prospective payment amounts or the capital cost pass through amounts were overstated, resulting in excess Medicare payments. We continue to emphasize that rebasing the Federal portion of the PPS rate using the 1982 or 1983 base year cost audits would correctly adjust the PPS rates. This would save the Medicare program about $5 billion -- the $2.25 billion discussed above plus the $2.8 billion previously reported. In addition, rebasing the Federal portion of the PPS rates would be consistent with HCFA's policy of using the best available data to establish future payment rates.

We are also forwarding a copy of this PAM to the Assistant Secretary for Planning and Evaluation for consideration in drafting revised reimbursement policy for capital costs under PPS.

We would appreciate receiving your comments on this matter by May 24, 1985.

Attachments

ESTIMATED ADDED COSTS TO MEDICARE PROGRAM DUE TO INCLUDING CAPITAL COSTS IN PPS RATES

	FISCAL YEAR					5-YEAR
	1986	1987	1988	1989	1990	TOTAL
	(— In Billions --)					
Estimated Medicare Inpatient Hospital Payments Under PPS 1/	$43.00	$45.15	$47.40	$49.78	$52.26	$237.59
Less: Estimated Payments to Waiver States 2/	7.53	7.90	8.30	8.71	9.15-	41.59
	$35.47	$37.25	$39.10	$41.07	$43.11	$196.00
Cost to Medicare Based On a 1.2 Percent Over-statement of PPS Rates 3/	$ .32	$ .45	$ .47	$ .49	$ .52	$ 2.25

Notes: 1/ The Medicare hospital payments are based on an estimate by the Assistant Secretary for Planning and Evaluation for 1984 of $39 billion, increased annually by a 5-percent inflation factor.

2/ The estimated Medicare hospital payments were reduced to eliminate estimated payments for the hospitals in the four waiver states. A 17.5 percent reduction was computed based on the ratio of total costs of hospitals in waiver states to total costs for all 5,631 hospitals in the fiscal year 1981 cost data.

3/ The national average discharge cost will be the basis for 75 percent of the payment rate during 1986, the last year of the phase-in period. Our estimate has been adjusted accordingly.

ESTIMATED AMOUNT INPATIENT OPERATING COSTS WERE OVERSTATED DUE TO INCLUSION OF DIRECTLY ASSIGNED CAPITAL COSTS

	COSTS REPORT DATA (IN MILLIONS)			
	1982 OR 1983 134 HOSPITALS		1981 5,631 HOSPITALS	
	TOTAL	MEDICARE SHARE 2/	TOTAL	MEDICARE SHARE 2/
Total Inpatient Costs	$2,019	$666.3	$86,171	$28,429
Identifiable Inpatient Capital Costs	181	59.7	5,658	1,867
Inpatient Operating Costs	$1,838	$606.6	$80,513	$26,562
Directly Assigned Inpatient Capital Costs	22	7.3	966 1/	319
Actual Inpatient Operating Costs	$1,816	$599.3	$79,547	$26,243

1/ To estimate the amount 1981 inpatient operating costs were overstated, we applied the percent ($22 million ÷ $1838 million or $7.3 million ÷ $606.6 million = 1.2 percent) of directly assigned (first time identified) capital costs included in total inpatient operating costs of the 134 hospitals to the 1981 total inpatient operating costs.

2/ Medicare's share was based on the ratio of total Medicare payments to total inpatient costs in the 1981 cost report data for 5,631 hospitals.

Chairman **Stark**. Mr. Kusserow, you were here during the testimony of the previous panel.

Mr. **Kusserow**. Yes, Mr. Chairman.

Chairman **Stark**. Did you hear my question in terms of the return on equity as trying to establish a differential between paid in equity and that which just kind of builds up through a rapid appreciation?

Mr. **Kusserow**. Yes, Mr. Chairman.

Chairman **Stark**. Is that a valid distinction? It seems to me if you just—assume a hospital were one piece of equipment and if there were any sense in paying interest, say, it's a $10,000 piece of equipment, and that comprises a medical system. I guess you could give somebody interest on that piece of equipment. I suppose if you pay appreciation on some amortized equipment you would do that.

But if one is profit and the other is nonprofit and let's say you want to amortize the $10,000 piece of equipment at $1,000 a year and you give 10 percent interest, you will start paying $1,000 and run that down to zero over a period of time.

Don't you automatically, the way the books are kept with the system as it is now, add an extra marginal payment as the depreciation of the profit with transfers to equity? You then begin to pick up and pay them, now it's 12 percent but for symmetry, call it 10, but in effect, as the item is depreciated, if these were all 10's, the for-profit hospital would get a constant $1,000 payment, plus $1,000 of depreciation.

Mr. **Kusserow**. Right.

Chairman **Stark**. Whereas the nonprofit would get the $1,000 depreciation each year but get a declining payment for depreciation which would not be made up by that mandated return on equity. I am stating that right?

Mr. **Kusserow**. I couldn't agree with you more, Mr. Chairman.

Chairman **Stark**. Well, I just wanted to make sure there wasn't something in the rules I didn't quite see.

Mr. **Simmons**. We believe that is a valid point. I was noticing the reaction of the witness representing proprietary hospitals when you delivered that, how he was scribbling notes, so I think that was a point he had not considered either.

Chairman **Stark**. As I say, I make no judgment. It seems to me the way the rules work, in practice if that is what happens under a DRG system, it's a matter of indifference. I don't know why we pay them anything for cap or equity if we go to a PPS, pay by each procedure, it's a matter of if they can do something with less equipment, God bless them.

Mr. **Kusserow**. The seven issues we have supplied for the record supports that position exactly. We agree with you.

Chairman **Stark**. Great minds run in the same direction, Mr. Kusserow. Mr. Gradison, speaking of great minds.

Mr. **Gradison**. Thank you, Mr. Chairman. I will try not to let you down.

Mr. Zimmerman, your statement calls to our attention the unaudited hospital cost reports which were used as a basis for getting started on the DRG system. Unfortunately we didn't inquire earlier in this hearing of representatives from HCFA with respect to their reactions to this.

I wonder if you have received in writing or otherwise a response from them. It would be helpful to have that. It would be something that is certainly of importance, it is an important adjustment for us to consider.

Mr. **Zimmerman**. We discussed it with the staff involved in doing the computation initially for HCFA and they were surprised by the size of the difference that we came up with. We have not presented the information to the agency for formal comment, but I plan to do that as soon as I leave this hearing.

I will call on Dr. Davis and ask her if we can get together and discuss the numbers that are contained in our document.

Mr. **Gradison**. Under your normal procedure when would they have a chance to—when would they normally be expected to give you their comments on this?

Mr. **Zimmerman**. Normally when we send a draft report for advance review and comment we ask for 30 day comment period, but in view of the fact this may necessitate quicker action we can restrict the time frame and ask that they comment in 15 days.

Mr. **Gradison**. I hope you will because as we consider alternatives to a freeze, this is certainly a good one to consider. I hope that subsequent witnesses will comment on this as well. To make an adjustment of this size, it is something we ought to consider.

Mr. **Kusserow**. Mr. Gradison, when GAO submits its report to our department they will find an inspector general report that comes to similiar conclusions that very much complement the work they have done. We agree with them.

Mr. **Gradison**. Are they roughly comparable in terms of percentage adjustment, the amount of money involved?

Mr. **Kusserow**. They are in the ball park. We come in at a little different angle. With your permission, I would like to make those reports available to you so you can see how indeed they do complement although they come from a different angle.

Mr. **Gradison**. That would be extremely helpful.

Mr. **Simmons**. I believe the sum of the GAO issues involving the audited, unaudited and duplication of capital in the DRG rates amounts to a 4 percent overstatement or an additional pay-out, depending on what you call it, in the PPS.

So we are talking about a 4 percent overpayment as relates to a proposed freeze in PPS rates in fiscal year 1986. This additional amount has been provided gratuitously up to now and therefore a freeze won't really penalize them because they have been overpaid annually by the 4 percent spread.

Mr. **Gradison**. Thank you.

Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Rangel.

Mr. **Rangel**. No questions.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Thank you, Mr. Chairman.

Did one of your groups audit or take a look at the revised wage index calculations that have been proposed for issuance in regulation form on the 3rd of June?

Mr. **Kusserow**. Yes, Mr. Daub, the Office of Inspector General did indeed do that. In fact I must assume, I guess, some responsibility for some of the delay associated with the new wage index being developed because I am afraid that, when it was circulating in the Office of the Secretary, I expressed some scepticism about a new wage index in view of the fact it was the second time around in surveying the hospitals.

The first time around didn't bring very accurate results. So I counseled the Undersecretary and Secretary that I wanted to audit and validate the survey results so that when it was presented to the Congress the Department would have a supportable position.

There was risk associated with that because if we did do an audit and found we could not validate the results, then the Department would be very much exposed. But I felt that we should go ahead and do it.

Indeed, I did go ahead and we took a systematic sample of the hospitals that did report in. We audited that data and came up with extremely high correlation, about 1.0. We found wages and hours statistically came out to .99 correlation which is extraordinarily high.

So at this point I can say that the wage index has been validated and it could not possibly have a higher degree of validation as far as accuracy.

Mr. DAUB. You are talking about the adjusted gross or the gross?

Mr. KUSSEROW. Just the gross.

Mr. DAUB. Just the gross?

Mr. KUSSEROW. Yes.

Mr. DAUB. So it seems that is fairly commonly accepted. If the gross wage index were implemented you find it statistically to be very accurate?

Mr. KUSSEROW. Yes, Mr. Daub, the fact is that I gave a report to that effect to the Under Secretary on May 2 and with your permission I would like to leave that with you today.

Mr. DAUB. Would you do that? We might have that as part of the record, Mr. Chairman.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 2 1985

From /s/ Richard P. Kusserow
Richard P. Kusserow
Inspector General

Subject HCFA's Report to Congress on the Medicare Hospital Wage Index (ACN: 14-52059)

To Charles D. Baker
Under Secretary

The purpose of this memorandum is to document the results of our review of a random statistical sample of data gathered by the Health Care Financing Administration (HCFA) to compute hospital wage indices for use in the Medicare Prospective Payment System (PPS). Our sample results, along with other corrections, have been used by HCFA to revise the wage indices. The revised data was sent to the Secretary for approval on March 8, 1985.

Background

Public Law 98-21 required that the labor related portion of the Federal prospective payment rates be calculated by taking into account differences in wages among geographic areas. This adjustment is accomplished through an area wage index applied to all hospitals subject to the PPS within designated urban and rural areas.

The hospital wage index is presently constructed from a national data base of hospital wage and employment records maintained by the Bureau of Labor Statistics (BLS) of the U. S. Department of Labor. It is generally recognized that the BLS data contains technical limitations which raises concerns over the accuracy of certain wage index values. The principal limitation of the BLS data, the inability to recognize local differences in the number of part-time hospital workers, has been cited as a major problem in the PPS by a number of hospitals, particularly rural midwestern hospitals. Because of these concerns, Section 2316(a) of the Deficit Reduction Act of 1984 required the Secretary to conduct a study to develop a wage index which addresses the part-time employment problem.

HCFA performed the study during calendar year 1984. It involved both fiscal intermediaries and hospital personnel in gathering data on wages paid and hours worked by hospital employees. During the data gathering, HCFA recognized some inconsistencies with the information received. Attempts were made to purify the wage and hour data before preparing the required report to Congress on the revised hospital wage index. A proposed report was prepared by HCFA on January 3, 1985 for clearance through the STAFFDIV's. HCFA had computed a wage index for each of 363 geographical areas as defined by the Executive Office of Management and Budget.

We reviewed HCFA's proposed report and raised several issues that needed to be addressed before the report was ready for the Secretary's signature. Among others, we noted that an independent verification of the wage data had not been performed. At your direction, we initiated a joint review with HCFA of the wage and hour data used to develop the area wage indices.

Verification of Wage Data

As a part of our joint venture, we assumed the lead and:

- Developed a sampling plan which allowed for the extraction of a random statistical sample from the data submitted by the hospitals subject to PPS. We selected a sample of 200 hospitals and decided to review, on an incremental basis of 50 hospitals at a time, the accuracy of the wage and hour data submitted.

- Prepared an audit guide for use by the field auditors. The guide prescribed the minimum audit tests to be performed to verify the providers' wage and hour data and included an audit report format for transmitting the audit results to us and HCFA.

- Monitored the progress of the field audits which were performed by the Medicare fiscal intermediaries and our auditors. We answered numerous technical questions and reviewed the individual audit reports to resolve discrepancies.

Results of Reviews

The results of the initial 50 provider audits showed that the data reported to HCFA by the fiscal intermediaries and certified by the hospitals was basically accurate (see Attachment I). For 14 of the 50 audited providers, both the hours and wages previously reported to HCFA were verified as being correct. For the other 36 providers, audits found discrepancies which, in the aggregate, resulted in a $314,598 overstatement of wages and 155,415 understatement of hours.

Notwithstanding these differences, our analysis of these statistical data indicated a very high correlation of accuracy between the wage data reported to HCFA and the results of the audits. In fact, the correlation coefficient between the reported wages and hours and the wages and hours verified during the audits was .9999. This correlation coefficient is a statistical measurement of the strength of the relationship between the reported data and the verified data. Mathematically, the correlation coefficient cannot exceed +1 nor be less than -1. The closer a computed correlation coefficient is to one of these values, the stronger the relationship. A correlation coefficient of .9999 shows that providers generally reported accurate wage and hour data to HCFA. The use of such data should yield valid wage indices. Because of the extremely high correlation, we did not expand the random sample to include any additional providers.

Although overall the data reported to HCFA appeared to be accurate, concern continued over why certain areas had wage indices developed by HCFA which deviated significantly (called "tails") from the present BLS wage indices used in PPS. Therefore, audits were performed on an additional 123 providers included in geographical areas in which HCFA's initial index results varied by greater than 10 percent from the BLS index results. These audits showed that the 123 providers had over-reported wages by approximately $10.3 million and under-reported time by approximately 9.7 million hours.

HCFA revised the wage indices by incorporating the results of the 173 audits in its calculations. As a result, the number of "tail" geographical areas was reduced from 19 to 11 localities (see Attachment II). In 9 of the 11 "tail" localities, an audit was performed on each provider's wage and hour data used in the computation of the revised index for that area. The conclusion can then be made that the difference between HCFA's wage index and the BLS index is not the result of HCFA using incorrect data.

Revised Report to Congress

On March 29, 1985 the Secretary transmitted a revised report to Congress on the Medicare hospital wage index. HCFA's impact analysis of the revised wage index, incorporating results of the 173 audits, indicated in the aggregate that implementing the new wage index values will result in a $7 million reduction in PPS outlays to participating hospitals.

If you would like any additional information about the wage index audits, please call me. A copy of this report is being provided to Carolyne Davis, John O'Shaughnessy, Robert Helms, and Terry Coleman.

APPENDICES

ATTACHMENT I

VERIFICATION OF WAGE INDICES
RESULTS OF AUDIT OF 50
RANDOMLY SELECTED PROVIDERS

Sample Provider Number	Errors Detected by the Auditors	
	Wages (a)	Hours (a)
1	$ 591	6
2	(273,423)	(9,347)
3	423,425	(29,600)
4	(22,193)	(27,436)
5	-0-	-0-
6	(33,871)	(7,471)
7	437,432	14,502
8	-0-	17,673
9	18,061	5,173
10	-0-	(8,177)
11	-0-	(35,628)
12	-0-	(783)
13	-0-	3,545
14	(167,673)	9,134
15	-0-	(15,114)
16	-0-	(8,173)
17	-0-	(445)
18	1,478	(7,214)
19	-0-	(49,232)
20	(104,917)	17,425
21	-0-	-0-
22	-0-	-0-
23	-0-	(8,942)
24	123,074	142,486
25	98,822	(41,587)
26	(7,180)	1,807
27	-0-	-0-
28	-0-	3,624
29	-0-	-0-
30	239	(18,352)
31	16,785	(997)
32	-0-	-0-
33	(335,711)	(8,914)
34	-0-	-0-
35	99,863	(13,777)
36	23,582	-0-
37	-0-	(15,130)
38	-0-	(22,847)
39	-0-	-0-
40	-0-	-0-
41	-0-	(9,306)
42	-0-	(3,619)
43	-0-	-0-
44	(2,696)	4,268
45	-0-	-0-
46	18,910	(25,573)
47	-0-	-0-
48	-0-	-0-
49	-0-	-0-
50	-0-	(8,394)
Totals	$314,598 (b)	(155,415) (c)

NOTES:

(a) The amount shown by provider represents the difference between the amount reported by the provider and the amout verified by the auditors.

(b) The 50 providers collectively overstated wages by this amount. Holding other factors constant, the overstated wages would cause an index to be higher than it would be if it were computed with the correct amount.

(c) The 50 providers collectively understated hours by this amount. Holding other factors constant, the understated hours would cause an index to be higher than it would be if it were computed with the correct amount.

ATTACHMENT II

IDENTITY OF "TAIL" GEOGRAPHICAL AREAS

Locality *	Identified as a "tail" area: Using Unaudited Data	Identified as a "tail" area: Using Audit Results
Asheville, NC	Yes	No
Boulder-Longmont, CO	Yes	Yes (a)
Brazoria, TX	Yes	No
Charlottsville, VA	Yes	Yes (a)
Fort Collins-Loveland, CO	Yes	Yes (a)
Hawaii (Rural)	Yes	Yes (a)
Killeen-Temple, TX	Yes	No
Lawton, CO	Yes	No
Midland, TX	Yes	No
Nashville, TN	Yes	Yes (a)
Oakland, CA	No	Yes
Pueblo, CO	Yes	No
San Antonio, TX	Yes	Yes (a)
San Francisco, CA	No	Yes
San Jose, CA	Yes	No
Santa Rosa-Petaluma, CA	Yes	No
Shreveport, LA	Yes	No
Syracuse, NY	Yes	Yes (a)
Texarkana, TX-AR	Yes	Yes (a)
York, PA	Yes	No
Yuba City, CA	Yes	Yes (a)

NOTES:

* A "tail" locality is defined as a geographical area in which the HCFA wage index result is greater than ± 10 percent of the BLS wage index result.

(a) Audits, as part of our special study, have been performed on the wage and hour data of each provider located in this geographical area.

Mr. **Simmons**. Can I clarify?

Chairman **Stark**. Without objection.

Mr. **Simmons**. We got high correlation between the reported and audited of almost 1.0, which in statistical terms is perfection. What we can't say is whether the Medicare index that HCFA proposes is better than the old one. We struggled with that question.

You can't really tell which one is better, which one is worse, one results in different outcomes to hospitals than the other. We tried to find the reasons for that. We couldn't do it for a lot of reasons, the primary one being that the Department of Labor information is protected by law. You can't find out how they construct the data. When we went to the hospitals, we asked them for the information that they had submitted to the State or to Department of Labor or used in the construction of those hospital indices.

They couldn't answer that because they didn't know. So we verified the information report to HCFA.

What we don't know and HCFA doesn't know is which index is better.

Mr. **Daub**. I understand that. As useful as that may be, the one thing we want to be sure of is, if we go, in our wisdom, to a different wage index, the one we go to must be workable, usable, accurate, and not upset the apple cart in any way, shape or form.

Mr. **Kusserow**. The information supplied by the hospitals in this survey is accurate. We have validated that.

Mr. **Daub**. Did you look at that?

Mr. **Zimmerman**. No, sir, we did not.

Mr. **Daub**. Thank you. We appreciate the letter being part of the record.

Thank you, Mr. Chairman. I have no other questions.

Chairman **Stark**. I want to thank you all very much, and it is useful information which is something we can take action on I am sure. We appreciate very much your efforts in this regard.

Mr. **Daub**. Thank you all. We appreciate it.

Mr. **Kusserow**. Thank you, Mr. Chairman, Mr. Daub.

Mr. **Simmons**. Thank you.

Chairman **Stark**. Our next panel will be Mr. Richard Norling of the California Hospital Association, and Tommy R. McDougal, of the Alabama Hospital Association.

Mr. Norling is accompanied by people whom he will introduce. Would you like to introduce your accompanying witnesses?

STATEMENT OF RICHARD A. NORLING, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CALIFORNIA HOSPITAL MEDICAL CENTER, ON BEHALF OF THE CALIFORNIA HOSPITAL ASSOCIATION

Mr. **Norling**. I would indeed. With me is Thomas Wilburn representing the Ohio Hospital Association, and Mr. Donald Oder representing the Illinois Hospital Association.

We three are here in behalf of a much larger coalition of hospitals from the New England area, Midwest/Great Lakes, and Pacific regions that are losing hospitals under the transition to a national rate. We strongly urge you to support a pause in this transition while major flaws are being corrected.

We have submitted written testimony which we ask be incorporated into the record of today's proceedings.

Chairman STARK. Without objection.

Mr. NORLING. Specifically, I would like to illustrate rather than read the testimony with specific examples from my institution.

I am president of the California Hospital and Medical Center, which is a 327-bed nonprofit community hospital in downtown Los Angeles. The 5-mile radius encompasses the lowest per capita income residential population in Los Angeles County. It also encompasses burgeoning redevelopment associated with the central city growth.

We have been located in downtown Los Angeles since 1887 and have focused on the primary health care of our community without regard to the various economic cycles through which it has gone.

As such, a current reflection of that shows our patient load to be currently 42 percent Medicare, 30 percent Medicaid called MediCal in California, and additional 5 to 8 percent fall in the category of bad debts and various charitable allowances.

As such, this leaves only 20 percent of our business to pay our prices or increasingly our negotiated rates that will indeed cover the shortfalls associated with the remaining 80 percent.

As an institution, we have combined our commitment to our community with a strong business-like approach to the cost-effective delivery of service. We have always attempted to stay ahead of the environment and react prospectively to anticipated change versus reacting retrospectively.

We are very supportive of fundamental changes in the payment mechanisms occurring in the environment, specifically the PPS mechanisms.

We believe that prospective payment as a ramification of the health care market provides proper incentives to the health care system and we are reacting appropriately to those incentives. Our concerns are with regard to the equity and adequacy of the payments under PPS. We would argue to hold the transition at this point to a national rate until the inequities can be corrected.

Consistent with California Hospital's commitment to stay ahead of the environment, let me illustrate a program that began over 40 months ago at our institution. We began at that point with a commitment to hold our rates flat so for 40 months we have not increased our prices.

In addition, our costs per case have remained flat during that entire period. We have worked hard on aspects of utilization management focusing on extreme use in per-patient day. We have been frustrated by many of the facts Mr. Mongan identified associated with our particular area, with respect to cutting length of stay.

We have organized a marketing function and we have been energized to solicit private sector contracts from various insurance, HMO and trust funds to the point where we have signed 43 different contracts with this private paying environment.

We have begun diversifying, recognizing that inpatient care is not exactly a growing line of business at the moment and we have been looking specifically both at external philanthropic support to enhance quality in our basic inpatient and other programs, as well as other revenue diversification.

In our area, real estate has a substantial interest to us and we are looking at those sorts of items to find outside revenues to help support our basic purpose.

In short, I would suggest that we have done all the things that the incentives inherent in PPS would lead us to do, be it a 50-percent national rate or 100-percent national rate. In spite of a disproportionate load as I think the numbers indicated of Medicaid and other indigent patients, we have been able to maintain a small but positive bottom line to this point.

We are now faced with a continuing transition to national PPS rates, and that transition this year alone will cost us $700 per Medicare case. That is our estimated volume of 2,500 to 3,000 Medicare cases, so we are talking about a financial impact in our institution of 300 beds, of somewhere between $1.5 and $2 million.

Despite our best management efforts, this is too much too quickly to maintain our institution in our financing base.

There are a lot of reasons, Mr. Chairman, why we believe a pause is approriate and fairness is the absolutely correct one. There are many inequities that need correction.

I would ask my colleagues be permitted the opportunity to add.

[The prepared statement follows:]

STATEMENT OF RICHARD A. NORLING, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CALIFORNIA HOSPITAL MEDICAL CENTER, ON BEHALF OF THE CALIFORNIA HOSPITAL ASSOCIATION

SUMMARY

The California Hospital Association strongly supports the environment created by the Medicare Prospective Pricing System (PPS) and other purchasers and providers of care. However, continuing the scheduled transition of the badly flawed PPS system away from hospital-specific to national payment rates will force many of this country's most vulnerable hospitals—those that the poor and elderly depend on for the majority of their health needs—as a matter of survival to restrict their services to this group of patients. Even without a freeze on Medicare payments to hospitals, the system's major problem areas will cause severe arbitrary financial dislocation for some institutions, and undeserved wind-fall profits for others. The flaws, combined with a freeze and a continuing transition, will cause drastic financial damages. A partial solution would be an immediate implementation of the revised gross wage index.

The Subcommittee should oppose the continuing of the transition until the administration adequately responds to the need to recognize the unique requirements of this nation's disproportionate providers.

CHA supports the American Association of Medical Colleges' position on the freezing of cost reimbursement for direct medical education and for reducing the allowance for indirect medical education costs.

Finally, the Subcommittee should demand the numerous mandated, but undelivered, reports from HCFA. Until such time as they are submitted, Congress should be very sensitive to the very real and potential damages the currently designed system may cause on our most needed hospitals.

STATEMENT

I am Richard A. Norling, President and Chief Executive Officer of the California Hospital Medical Center in Los Angeles. The California Hospital Medical Center is a nonprofit 325 bed facility located in the downtown section of Los Angeles. Forty-two percent of our patients are Medicare, and over 30 percent of our patients are Medi-Cal.

I am testifying on behalf of the California Hospital Association and its 400 institutional members in opposition to the administration's proposed freeze on Medicare hospital rates. Yet California hospitals, like those in Illinois, Ohio, Massachusetts, Wisconisn and Michigan, are willing to carry their fair share in solving the budget deficit problem. However, at the same time, and as a safety net for these and other institutions across the nation, we urge this committee to provide a period of hospital payment predictability and stability by interrupting the scheduled transition to national payment rates. This interruption, which would have absolutely no effect on Medicare savings, would ensure that hospitals' payment rates would continue to provide some protection from the major flaws of the currently designed system. These major problem areas, including failure to adequately adjust for the varying severity levels of patients in the same diagnostic category, failure to recognize the unique costs of hospitals treating a disproportionate share of aged and indigent patients, failure to recognize the regional variations in the costs of goods and services which hospitals must purchase in their local economies, and failure to adequately adjust for hospital labor costs, will have a greater and greater arbitrary impact on hospitals as the payment blend moves from hospital-specific to national rates.

California Hospital Medical Center is, by just about any definition, a disproportionate provider. We have 30 percent of our business in Medi-Cal, 42 percent in Medicare and over 8 percent in bad debt and charity care. We feel the basic direction of Medicare's Prospective Pricing System is good. The environment is tough, but provides appropriate and positive incentives. The environment is one that is leading us in the proper direction, forcing us to be cost effective, forcing us to make tough changes—but the key is timing and the ability to accommodate to the need to obtaining financing to make these changes work. The rapid transition to the national rate, the freeze on Medicare rates, and reductions in indirect teaching allowance, takes away needed financing that hinders our ability to appropriately respond and anticipate this new environment.

These cuts are drastic in institutions like ours. We have little private pay business and what we have is mostly under contracts subject to limitations.

We need time to deal with all the factors, not just Medicare, but Medicare is the biggest. Without sufficient time to systematically adjust to the new environment, hospitals that are committed to the indigent, if force, are going to have to, in the short term, take the majority of their cuts out of their cuts out of their indigent care commitments even if it means closing up services with heavy indigent care loads. It is a survival instinct—closing programs taht provide access for the indigent.

The California Hospital Medical Center, with an October 1 fiscal year, has been under the Prospective Pricing System since day one. We are today, half way through the transition period to national payment rates. And I'm here today to tell you that it's too fast. We have been able to hold our cost flat for over fourteen months, and are pursuing just about every internal and external cost saying action we can find—yet the hardest time is still ahead if the transition continues on its current schedule and the major problems remain unsolved.

As you will note in the attached table, if the price freeze proposal is adopted, and the transition continues, there is a significant re-distribution of Medicare payments among hospitals. While not affecting the aggregate amount of Medicare outlays (extending the transition would be budget neutral), this re-distribution will profoundly affect the amounts paid to individual hospitals. More specifically, if the transition continues and a freeze is adopted at the same time, many hospitals will receive substantially less in Medicare payments for the same types of patients that they were paid this year. For them, this is not a freeze—it's a steep cut in payments.

In our state, the estimated impact of continuing the transition to national rates will be a loss of $91 million in Medicare hospital payments. If Medicare's PPS rates are frozen and the transition continues, California hospital's will loss an estimated $276 million in Medicare payments. Cutbacks of this magnitude simply cannot be accommodated without dislocations and service disruption. We believe the quality and accessibility of hospital services will decline—not just for Medicare beneficiaries, but for all the citizens of the state.

We believe that the Administration's price freeze is ill-timed and unfair in its own right. Price freezes were not envisioned by Congress in the PPS, and certainly, they can threaten the stability and fairness of the system. Arbitrary and unanticipated price cuts undermine the fiscal viability of hospitals and make financial planning virtually impossible, when this price freeze is combined with a continued transition, it compounds the problem by causing massive re-distribution of hospital payments.

In fact, there are good reasons to slow the transition independent of what action is taken on the freeze. The list of defects which have been identified in the PPS is growing—much faster than our capacity to put remedies in place. There is much important work on refinements of the PPS that is underway, but cannot be completed in time to rectify these problems by next year.

The original transition schedule to reach a national pricing system was ambitious; and, in light of these problems, we believe there are compelling reasons for an extension of the phase-in period. If, in fact, hospitals are faced with a price freeze, simple fairness demands that, during the period of the freeze, the massive re-distribution of Medicare funds that would result from current PPS rules, and the further reductions in payments to many institutions it will cause, should be postponed.

Mr. Chairman, please be assured that we support the Prospective Pricing System, we are as committed to it as you are. Clearly, the efficiency behavior incentives inherent in the current system is having the desired results: Medicare cost increases have dramatically decelerated from over 18 percent three year ago to below 5 percent this year. With this demonstrable success already behind us, we question the need to continue the transition towards national rates until the system's major flaws are resolved. We are very anxious that the next phase of the transition, 25 percent hospital-specific and 75 percent federal, combined with inadequate rate increase, if any, will severely jeopardize many hospitals ability to continue the same level of commitment to their communities' aged, as well as indigent patients. The fact is that the change agent is the set rate, not a set rate: thus, the incentive to change behavior to increase efficiency will remain while the transition is interrupted.

We urge you to consider a simple pause in the transition, an interruption for twelve months during which our associations pledge to work with you to make Medicare's Prospective Pricing System as fair and equitable as possible.

ESTIMATED 1986 CHANGES IN MEDICARE REIMBURSEMENT RELATIVE TO 1985 CAUSED SOLELY BY THE CONTINUED TRANSITION TO NATIONAL RATES

	Amount (millions)	Change (percent)
United States	0	0
Alabama	$10	1.6
Alaska	0	−.5
Arizona	7	1.6
Arkansas	19	5.1
California	−91	−2.3
Colorado	8	2.1
Connecticut	3	.7
Delaware	−1	−1.7
District of Columbia	−10	−5.8
Florida	8	.4
Georgia	25	3.7
Hawaii	1	1.1
Idaho	1	1.6
Illinois	−77	−3.5
Indiana	−5	−.6
Iowa	3	.7
Kansas	−5	−1.1
Kentucky	22	4.4
Louisiana	10	1.9
Maine	−3	−1.6
Maryland (W)	−2	−.4
Massachusetts (W)	−34	−2.9
Michigan	−23	−1.5
Minnesota	8	1.1
Mississippi	3	.9
Missouri	−32	−3.3
Montana	1	1.3
Nebraska	−2	−.7
Nevada	−4	−2.8
New Hampshire	−1	−1.0
New Jersey (W)	28	2.5
New Mexico	2	2.1
New York (W)	11	.3
North Carolina	24	3.3
North Dakota	0	−.3
Ohio	−16	−.8
Oklahoma	9	2.0
Oregon	9	2.3

ESTIMATED 1986 CHANGES IN MEDICARE REIMBURSEMENT RELATIVE TO 1985 CAUSED SOLELY BY THE CONTINUED TRANSITION TO NATIONAL RATES—Continued

	Amount (millions)	Change (percent)
Pennsylvania	36	1.5
Rhode Island	1	.3
South Carolina	2	.7
South Dakota	0	.5
Tennessee	29	3.7
Texas	4	.2
Utah	3	2.7
Vermont	0	.7
Virginia	6	.8
Washington	24	4.4
West Virginia	4	1.3
Wisconsin	−19	−2.6
Wyoming	0	−.3

Estimated 1986 changes in Medicare reimbursement relative to 1985 caused solely by the continued transition to national rates

[Number of hospitals losing and gaining]

Losing	
Less than $100,000	930
$100,000 to $249,999	532
$250,000 to $499,999	380
$500,000 to $999,999	280
$1,000,000 to $4,999,999	181
$5,000,000 or more	3
Gaining:	
Less than $100,000	1,642
$100,000 to $249,999	714
$250,000 to $499,999	415
$500,000 to $999,999	275
$1,000,000 to $4,999,999	149
$5,000,000 or more	2

STATEMENT OF DONALD R. ODER, SENIOR VICE PRESIDENT AND TREASURER, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER, ON BEHALF OF THE ILLINOIS HOSPITAL ASSOCIATION

Mr. ODER. I am Don Oder, senior vice president of Rush Presbyterian, St. Luke's Medical Center in Chicago, as well as past chairman of the Illinois Hospital Association.

The situation in Illinois is not significantly different from California, so I will not repeat what has been said.

Congressman Porter has also talked about Illinois and mentioned the $200 million impact of going to national rates.

Chairman STARK. I would be remiss if I didn't point out that Chairman Rostenkowski has whispered a few words in my ear as well. So I don't want Illinois to feel they are all alone.

Mr. ODER. We need to say it over and over again, though. Thus, $200 million affects all types of hospitals, large, small, the urban, and the rural. Rush has about 40-percent Medicare, and 14-percent Medicaid and charity care, so any change in Government reimbursement has a very significant impact.

Like California, we have adopted the Medicaid contracting system, and next year Medicaid will pay us 57 cents on the dollar as compared to what the private patients pay.

Cost shifting to the private sector we think is a thing of the past, and that is not a source of revenue. So as the national rates phase in, this will cost Rush about $18 million. Now, we have $27 million in the written testimony but that includes the movement from the 75–25 to the 50–50. So it is about $9 million each phase that we go into toward the national rate.

The movement from the 75 to—to the 50–50 will begin for us July 1 so that we have coped with in the budget by reduction of 420 employees and eliminating any net operating income.

Future transitions, however, will obviously have to come from programs and we will look at the community service type programs that we are providing without reimbursement, such as a poison control center. We have large educational programs, college and graduate in medical education, all of those we will look at.

So while we have coped so far to the 50–50, any further transition will cut very deeply I feel into these programs.

Thank you.

[The prepared statment follows:]

Statement of Donald R. Oder, Senior Vice President and Treasurer, Rush-Presbyterian-St. Luke's Medical Center, on Behalf of the Illinois Hospital Association

Mr. Chairman and members of the subcommittee, my name is Donald R. Oder and I am senior vice president and treasurer of Rush-Presbyterian-St. Luke's Medical Center and past chairman of the Illinois Hospital Association. IHA appreciates this opportunity to present its views on an issue crucial to Illinois hospitals and is grateful to the subcommittee for its recognition of the issue through this hearing.

The Illinois Hospital Association represents 240 community hospitals, 229 of which are currently participating in Medicare's Prospective Payment System (PPS). These hospitals have embraced PPS and have responded to its incentives for efficiency and cost containment. In calendar year 1984, when all PPS hospitals experienced at least some time under the system, Illinois community hospital expenses increased only 2.6 percent compared with a nationwide increase of 4.5 percent. The average cost to the consumer for a hospital stay rose 4.2 percent in Illinois compared with 1983. That increase is considerably below the 6.1 percent increase in the medical care component of the consumer price index (CPI). The average length of stay for patients dropped 7.4 percent compared to the national average decrease of 5.1 percent. In addition, our reduction in inpatient days paralleled national activity.

Cost efficiency and planning, however, cannot offset a basic flaw in the system: nationally based DRG rates. Although it is recognized that the statute allows for a wage adjustment, it must be recognized that when a national rate is fully implemented, beginning with hospitals whose cost reporting years begin October 1, 1986, that wage adjustment will be applied to the same labor-related base nationally. The formula therefore assumes that all hospitals not only have the same proportion of labor and non-labor expenses, but that the dollars expended are relative also. Carried one step further, the statute as written seems to say that hospital cost differences not specifically addressed and accounted for in the legislation are not justified and should not exist. Certainly this is an unrealistic approach to a complex problem!

When he first introduced prospective payment to Congress in December of 1982, then Secretary of Health and Human Services (HHS) Richard Schweiker's report openly recognized that many factors in the hospital expenditure environment are uncontrollable, including population growth and composition, demographic factors, development of new technology, income and insurance coverage, general inflation in the price of goods and services hospitals must buy, and mix of illnesses prevalent in the population. However, even after all this was brought to light only a wage adjustment was adopted.

One may question the rationale for a move toward nationally based rates because the formula will not in any way alter total dollars the federal government spends for hospital inpatient services to Medicare beneficiaries. The national rate merely redistributes those funds. For Illinois, an estimated $200 million will flow from our state to others when moving from the second to the fourth year of the phase, when national rates are fully implemented. The loss comes from both large and small, urban and rural facilities. When the enabling statute was adopted, Congress recognized the tremendous redistributions a national rate would cause, and provide a four year phase-in period. The phase-in however, does not alleviate the problem.

The current fiscal crisis has brought about a proposal by the Adminstration to freeze hospital payment rates for FY86 at the same level as FY85 but continue the transition to a national rate. For hospitals whose DRG payments are currently above the national rate, this will in fact generate not a freeze but a rollback in payments; a fact already recognized by the Ways and Means Committee in their report on the Adminstration's Fiscal Year 1986 Budget Proposal.

At Rush-Presbyterian-St. Luke's Medical Center, approximately 40 percent of our patients are Medicare beneficiaries. An additional 14 percent are indigent and charity care patients. A Medicaid contracting system has been established in Illinois where in 1986 we expect to receive 57¢ on the dollar for patients we treat.

We have to maintain the delicate balance of service to the consumer, the community, and education and research. Our Anchor HMO program has served Chicagoland since 1973, maintaining competitive prices and operating at 400 days per 1,000 enrollees compared to the 800 days per 1,000 common for conventional insurance plans. July 1, 1983, was the last time our hospital raised its prices, and we hope to continue that price freeze through June 30, 1986.

Hospitals do not operate in a vacuum of one payment program nor one set of incentives, nor can they be held accountable for the economic environment in which they operate. Our service area encompasses the Chicago metropolitan area where relatively affluent communities tend to increase demand for health care services and pockets of poverty may increase the intensity of care needed.

As the funding for state and federal programs has decreased without a significant change in expected benefits and the Illinois Healthcare Cost Containment Council has begun to monitor hospital price increases, our hospital has taken serious measures to remain fiscally responsible. Our fiscal year end is June 30, and although we have been under prospective payment less than one year, we have seen the need to change our staffing patterns in order to reduce 420 FTE's from our payroll. According to our estimates, if the Prospective Payment System is phased to national rates, we will see a reimbursement reduction of 40% per patient or approximately $27 million. This estimate is due to the transition alone and does not address additional considerations such as a reduction in medical education funding, outliers, or whatever alternative may be selected for payment of capital.

Hospital care as other industries has two sides, price and quality. However, unlike some other industries if our quality is reduced, human lives are directly affected. Our hospital studied this issue and in a recently published article brought to public attention the fact that quality of care may suffer under the system as it is currently written because DRG's don't adequately account for the cost of care. Severely ill patients who require specialized care are more likely to be admitted or transferred to a tertiary care hospital such as ours. But, in our medical intensive care unit we lose $10,500 for each Medicare patient we treat.

We have already begun reevaluating our non-revenue producing community service project, such as our designation as the Northern Illinois Poison Control Center, for which we receive no state or federal funding.

We must reevaluate the ability of the hospital to subsidize educational programs such as nursing, and have begun to reduce the number of residents in our graduate medical educational program. Also of concern is our continuing ability to commit resources to our research programs that, among other things, study cardiovascular diseases and conduct cancer research.

Costs to do business in Illinois are higher than in other states. Factors such as 6% higher energy costs, construction costs which rank as the eighth most expensive in the nation, 27% more unemployment and 36% more unionized employees are reflected in the products and services hospitals must purchase.

The Congressional Delegation of Illinois is concerned with the effects a national DRG rate will have on the state's health care delivery system. Both Congressman Rostenkowski and Senator Dixon have written to the Secretary of Health & Human Services asking about the status of a study required by the Deficit Reduction Act (PL 98-369) to analyze the degree of variation in costs within a diagnosis related group. In addition, the study will present alternative methods of computing payment and include a discussion of the relative merits of a method of payment under which a percentage of the payment (within the DRG) is determined on a regional basis.

In her reply of March 20, 1985, to Senator Dixon, the secretary said it would take at least a year to produce a "reasonably responsive, research-based report" to Congress on the results of studies concerning certain aspects of the Prospective Payment System. A freeze in the PPS blend would give HHS that additional year so Congress and HHS can make reasonable improvements in the system without causing unintentional and unwarranted hardships. If it is necessary to freeze Medicare rates, we urge Congress to also freeze the PPS transition period. Illinois hospitals will work with Congress and the Administration toward a fair method of distributing the funds that are available to hospitals for treatment of the elderly and disabled among us.

IHA appreciates the opportunity to testify. I will be pleased to answer your questions.

STATEMENT OF L. THOMAS WILBURN, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, BETHESDA HOSPITALS, ON BEHALF OF THE OHIO HOSPITAL ASSOCIATION

Mr. **Wilburn**. Mr. Chairman, members of the committee, I am Tom Wilburn, I am president and chief executive officer of Bethesda, Inc., of Cincinnati, and chairman elect of the Ohio Hospital Association.

I am here today in both capacities. I would like you to know that PPS is not a new idea in southwest Ohio. I have been in the health care business for the past 20 years and have functioned under this system in both Indiana and in southwest Ohio.

In southwest Ohio it has been on a negotiated basis over 30 years and we feel that system has helped our area become one of the more innovative and less costly areas in the highly industrialized Midwest.

As chief executive officer of Bethesda, I can strongly support prospective payment. As representative of the Ohio Hospital Association, I can testify that the OHA also strongly supports the concept of prospective payment. We do, however, have concerns with the proposals that you have before you.

First of all, we would like to say that you not freeze the hospital payment rate. The Prospective Payment System was put into place a short time ago and is just now having dramatic effects on health care for federally funded patients.

Second, we would like you to concern yourself with studies before any inclusion of capital is put into the DRG rates.

Third, while we recognize the difficulties with the Federal budget, and we do believe that health care is making significant strides, we ask that if you do choose to freeze the payment rate that you freeze the whole system, the inclusion of capital and the transition in the blending rates. The OHA believes that if Congress does not enact a pause in the current schedule the damage inflicted on certain Ohio hospitals will be too great to repair.

Delay in order to study the issue is an appropriate response, we feel, by Congress to the failure of the executive branch to carry out the mandates that were enacted in the social security amendments of 1983.

Congress recognized going in that the DRG system would be flawed, but, in seeking a system that works, you asked in the social security amendments, that the Secretary review, report and make recommendations on may areas. These included the impact of DRGs, the impact of computing payment rates on census regions, capital costs, return on equity, the urban-rural rates, payment methodologies for cost-based distinct part units and hospitals excluded from the DRG system, payment for outlies, severity of illness, intensity of care, and other modifications, sole community hospitals and uncompensated care.

To date, you and we are still awaiting the reports and recommendations on these issues. The short term actions that we take in response to problems rather than to data, are presently causing and we feel will continue to cause major disruptions within the health care community. I urge you not to wait until access to care for older Americans is jeopardized before thoughtfully considering appropriate long-term action.

There are exciting initiatives taking place in health care today. Hospitals, our hospital included, are participating in those initiatives and we are working to assure that effective and efficient delivery of health care continues.

In closing, I find that it is ironic that the President's budget message to Congress can assume that the current payment rates to all hospitals under DRG's may be excessive since the executive branch of the Government has failed to carry out the necessary studies and to report to Congress on the critical issues that are needed to determine the appropriate payment system for health services.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF L. THOMAS WILBURN, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, BETHESDA HOSPITALS, ON BEHALF OF THE OHIO HOSPITAL ASSOCIATION

SUMMARY

Health care providers are committed to provide cost-effective services to all patients and, in general, providers support the prospective payment system.

It is too early in the implementation of DRG's to make an adequate assessment of the program, particularly since the Secretary of HHS has failed to study, evaluate and make recommendations on certain issues in response to congressional mandates.

Any inclusion of capital in the DRG system must be carefully evaluated and based upon a methodology for the separation of old and new capital.

Congress must look at innovative private enterprise payment initiatives when considering incentives for Medicare beneficiaries to receive health care services in the most appropriate setting.

STATEMENT

Mr. Chairman and members of the Subcommittee on Health, my name is L. T. Wilburn, Jr. and I am president and chief executive officer of Bethesda Hospitals in Cincinati, Ohio. I am also chairman-elect of the board of trustees of the Ohio Hospital Association.

I am here today, both in my capacity as president of a multi-hospital corporation which operates two hospitals in the city of Cincinnati and as a representative of the Ohio Hospital Association, a trade association representing two hundred acute care general hospitals throughout the state of Ohio.

Southwest Ohio hospitals under a prospective payment system (which pays on the basis of negotiated charges) for many years even prior to the adoption of the medicare Program in 1966. This prospective payment system has provided the management incentives to make our area hospital costs among the lowest of any of the highly industralized areas in the state of Ohio and the Midwest. We, at Bethesda, and I, throughout my career, have operated under the philosophy of providing the most cost effective health care possible by emphasizing management control of resource utilization, productivity, and other sound business management practices. For your information, before coming to Southwest Ohio, I spent 11 years under the prospective payment system in the state of Indiana and helped develop many of the management and industrial engineering techniques which are used today throughout the health care industry.

As chief executive officer of Bethesda, I can testify that I strongly support the concept of prospective payment for health care services for Medicare beneficiaries.

As a representative of the Ohio Association, I can testify that the OHA also strongly supports the concept of prospective payment for health care for Medicare patients. I do, however, have certain concerns with the current proposals which are before you.

First of all, I ask you not to freeze the hospital payment rate as proposed by the administration. The prospective payment system was put in place only a short time ago and is just beginning to have dramatic effects on the delivery of health care. You have heard testimony from others and we have all read reports of significant savings occurring to the benefit of the Medicare Trust Fund. While the system has some major flaws which should be addressed, I do not believe that freezing the propsective payment rates is an appropriate action to take.

Secondly, I do have major concern and do believe that the inclusion of capital as fixed percentage with the DRG rate, as has been proposed, will cause major chaos within this nation. The inclusion of capital at a fixed percentage, based on historical averages, does not address legitimate differences in the age of existing facilities and capital structures. Simply put, if the average age of all the hospital assets in the United States is 15 years, then the payment for capital is based on construction costs and financing cost which are 15 years old. Ladies and gentlemen that doesn't make any sense. When you do consider the capital issue, I urge that you, in some way, separate old capital and new capital. I support a freeze on the inclusion of capital as part of the DRG rate until a method to separate old and new capital is adopted.

Thirdly, I recognize the current difficulites with the federal budget but I believe the health care industry is making significant strides toward solving its problem. If you do choose to freeze the propsective payment system, I urge you to freeze everything, the rates, the inclusion of capital, and the blending from hospital specific and regional rates to the national rate.

As a representative of the Ohio Hospital Association, I believe there are major flaws with the current DRG system which should be dealt with selectively, rather than by implementing a freeze on hospital rates. For example, as a community hospital, we must provide for certain basic services within the community. The current unbundling of hospital services, necessitated in many instances by federal actions, is actually driving up the overall total cost of health care while appearing to save money by transferring the delivery of services outside the recognized and established provider setting. We have equipment in our hospital (which must be maintained for inpatients) that is under-utilized on an outpatient basis because the Federal Government created incentives for physicians and entrepreneurs to duplicate those facilities outside the hospital. We thus have the same equipment which must be paid for over a period of time in two locations within a service area, rather than one. Ladies and gentlemen, this is a waste of resources caused by the creation of the wrong incentives.

The Ohio Hospital Association believes that if Congress does not enact a pause in the current schedule to national rates, the damage inflicted on certain hospitals within Ohio may be too great to repair. A delay, in order to study the issue, is an appropriate response by Congress to the failure of the executive branch to carry out the mandate that Congress enacted in the Social Security Amendments of 1983. The failure of the Secretary to carry out the mandates of Congress in both the Social Security Amendments of 1983 and the Deficit Reduction Act of 1984 are not limited to the DRG payment system. Recently the Ohio Hospital Association had to initiate legal action to force the Secretary to issue regulations setting appropriate payment limits for hospital based skilled nursing facilities. It has been over two years since Congress enacted Section 605 of the Social Security Amendments of 1983, and the health care industry is still waiting for these regulations.

Congress recognized "going in" that the DRG system would be flawed. But in seeking to set up a system which would work, Congress enacted Section 603 of Social Security Amendments of 1983. This Section required the Secretary of the Department of Health and Human Services to study, review, report and make legislative recommendations to Congress on issues related to:

A. The impact of the DRG methodology on hospitals, beneficiaries, and other payers.

B. The impact of computing payment rates on census regions rather than on a national basis.

C. Capital costs.

D. Return on equity.

E. The urban/rural rates.

F. Payment methodology for cost based distinct part units and hospitals excluded from the DRG system.

G. Payment for outlier cases.

H. Severity of illness, intensity of care and other modifications of the DRG payment system.

I. Sole community hospitals.

J. Uncompensated care.

To date, Congress and the nation are still awaiting the reports and recommendations on these issues. The silence of the Secretary in addressing these issues is forcing the provider community and Congress into short term actions, rather than the long term strategies which are more appropriate on a nationwide bases. These short term actions, often inadequately considered, are presently causing and will continue to cause major disruptions within the health care community. I urge you not to wait until the access to care for older Americans is jeopardized before thoughtfully considering the appropriate long-term action that Congress should take. Such severe short-term disruptions create opportunities within the health care system for individuals and companies to take advantage for their own personal and/or corporate gain. This is not in the ultimate best interest of the nation.

The health care delivery system is a very dynamic one! Changes occur almost daily as corporations, insurance companies, hospitals, and other providers test the market with new coverage programs, new incentives for their employees and other covered dependents, and new payment methodologies. I strongly encourage the Congress to investigate other payment mechanisms and coverage programs that are currently being developed by private enterprise. I also stongly encourage that Congress examine "additional incentives" which might be granted to medicare beneficiaries to assure that they receive both care services in the appropriate setting without artificial incentives which encourage the duplication of facilities.

There are exciting new initiatives taking place in the health care industry today. Hospitals my hospital included, are participating in those initiatives and are working to assure the effective and efficient delivery of health care services.

In closing, I find it ironic that the budget message to Congress can assume that the current payment rates to all hospitals under the Medicare DRG Prospective Payment System may be exessive since the executive Branch of the Government has failed to carry out the necessary studies and to report to Congress on the critical issues necessary to determine the appropriate payment system for health care services.

Chairman **Stark**. Thank you very much.

Mr. **McDougal**. I have been wondering why California has such outlandishly high costs. Now I know. You ask one witness to testify for each side and they sneak in three. If they do that in the surgical ward the way they do it here, no wonder they cost 3 times as much as medical care in Alabama.

I see that Alabama has sent one man to carry the message. We are pleased to have you here, and I am sorry you had to wait so you get a few extra minutes. Proceed in any way you are comfortable.

STATEMENT OF TOMMY R. McDOUGAL, PRESIDENT, ALABAMA HOSPITAL ASSOCIATION

Mr. **McDougal**. Thank you, Mr. Chairman, and members of the committee.

I am Tom McDougal of the Alabama Hospital Association.

I have been basking in the continuing references to Alabama's being a winner. We have been somewhat sensitive to that since the late 1860s. And I don't know the realities of all this, but I will try my best to be humble.

Mr. **Daub**. Let the record so show.

Mr. **McDougal**. I represent 168 hospitals in the State of Alabama who derive about 36 percent of their total revenues from the Medicare Program. The Alabama Hospital Association has been very active in taking positions relative to legislative matters at not only the State but at the Federal level as well.

I have filed a written statement which I would hope to have included in the record, Mr. Chairman.

Chairman **Stark**. Without objection.

Mr. **McDougal**. The Alabama Hospital Association feels that first and foremost there should not be a disproportionate application of the freeze on the hospitals and hence the beneficiaries of the Medicare Program. The Alabama Hospital Association has taken the position that we support PROPAC's recommendation of an increase in the Medicare rate of somewhere between 1 and 3 percent, and it is our opinion that this level of increase will continue to insure access and quality to the patients in the State of Alabama, but yet still make an active contribution on the part of the Alabama Hospital Industry to the Federal deficit problem.

We feel our hospitals have an obligation in that respect, but not a disproportionate amount of responsibility to that. Further, our Board has unanimously voted that we oppose any delay in transition from the 50-50 level for the third year of the PPS system. It is our opinion that the predictability and financial integrity of any prospective pricing system is the cornerstone that exists.

The hospitals of Alabama have made their competitive plans and fiscal plans on the basis of the predictability of what will happen in the third year of PPS.

I agree that Alabama would in fact be a benefactor of additional revenues as a result and I think that I would say that at the expense of other State associations and other hospitals that have gotten monies in the last year as a result of the same system, and I think that just the general objective of going to a national rate implies that these kinds of things will happen.

I think what the committee has to consider is to ensure that there is continued access and a minimum level of quality to the recipients regardless of where they are located. As a result of letting the process continue, the regional differences will be worked out.

I would not wish to imply there are not problems with the PPS. I think there are a number of things that need fixing in the system. And if it is broken they need fixing. Certainly we have innovation in this industry to compile and use the data that is coming from all this to be able to make rational decisions about those components of the system that need adjusting in order to create equity throughout the system.

If we wait until later this year to get this all together, we will only have 1983 data, the first year prior to PPS. What we need is effective consolidated data relative to operation of hospitals under PPS.

One thing that is unknown in all this is just how well have the hospitals responded to the initiatives of the system. I think that is a major question that is yet unanswered.

Mr. Chairman, I have a resolution which was not available to me at the time I filed my written statement that has been executed by a number of hospital associations which I would like to enter into the record.

Chairman STARK. Thank you. Without objection, it will be made part of the record.

Mr. McDOUGAL. This was signed by the Hospital Associations of Alabama, Arkansas, Louisiana, Mississippi, the Hospital Association of New York, Oklahoma, South Carolina, Tennessee and Texas. So it is not necessarily a regional issue. It is not a regional winner-loser situation.

Briefly, I would like to comment on at least two other matters, one of those being the area wage index. The Alabama Hospital Association has taken the position that we support the implementation of the gross wage index. We acknowledge that the implementing of that will impact Alabama hospitals; that we will impact—incur a loss as a result of that. But we feel strongly that the integrity of the prospective pricing system mandates that if that needs fixing, that it be fixed, and we will take our lumps on that.

With regard to medical education costs, I think that to do anything that has the trappings of nothing more than a budget deficit-reducing option is a little outlandish. There is relationship between medical education and hospital care and quality care and future supply of professionals that is not adequately covered by data.

Thank you.

[The prepared statement and resolution follow:]

STATEMENT OF TOMMY R. McDOUGAL, PRESIDENT, ALABAMA HOSPITAL ASSOCIATION

Mr. Chairman, I am Tommy R. McDougal, President of the Alabama Hospital Association (AlaHA). The Association represents 168 member hospitals and health care institutions that annually provide services to more than 600,000 Medicare beneficiaries in the state of Alabama. The Association also includes over 600 personal members and 3500 affiliated society members. I am pleased to have this opportunity to present AlaHA's views on certain issues relating to hospital payments under the Medicare program.

In this statement, I will first briefly comment on the Administration's FY 86 budget proposal to freeze payments to hospitals. Next, I will primarily focus on the key issue of delaying the prospective payment system's (PPS) scheduled transition toward national rates and away from hospital-specific rates.

In addition, this statement also will address several of the other proposals for changes to the Medicare PPS, including:

The advisability of implementing a new wage index and the related issue of the wage indexes retroactive application.

The advisability of eliminating the return on equity now included in the calculation of reasonable cost reimbursement for capital expenses; and.

The advisability of the Administration's proposal for freezing the cost reimbursement amounts for direct medical education.

FREEZE ON PROSPECTIVE PAYMENT SYSTEM RATES

Background and discussion.— The Administration's major health proposal is a freeze on hospital prospective payment rates for FY 86 at FY 85 levels. The freeze would extend to hospitals currently exempted from the system. However, freezing FY 86 payment rates at FY 85 levels is irrational, and should be avoided. Since 1981, Congress has enacted $22 billion in Medicare and Medicaid cuts. For FY 86, the Senate has just recently approved cuts totaling $3.9 billion.

AlaHA realizes hospitals must do their part along with all segments of society, to grapple with the critical problem of the federal deficit. However, it is unreasonable for Congress to place a disproportionate share of the burden for reducing federal spending upon the beneficiaries, and the hospitals which serve them.

Position.—A more rational approach would be for Congress to implement the update factor for the FY 86 PPS payments of between one and three percent called for by the Prospective Payment Assessment Commission (PROPAC). AlaHA supports the PROPAC recommendation for the FY 86 rate of increase. Such a rate of increase will permit hospitals to continue to provide quality care and maintain access, while still making a significant contribution to the deficit reduction effort.

TRANSITION DELAY

Background and discussion.—Medicare hospital payment methodology is in a Congressionally mandated four year transition from a cost-based, retrospective system to prospective pricing. Congress designed the prospective payment system to control Medicare cost and to provide incentives for all Medicare hospitals to operate more efficiently. That process began with cost-per-case limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) and continued with Medicare prospective pricing via the Social Security Amendments of 1983 (P.L. 98-21).

By the end of the first year of the PPS phase-in, September 30, 1984, a total of 5,405 or 81 percent of all Medicare hospitals nationally were operating under the prospective payment system. As hospitals enter the second year of prospective pricing, their payments for Medicare services will equal 50 percent of their hospital specific cost-per-case amounts, plus 37.5 percent of the regional average price per DRG, plus 12.5 percent of the national average price (i.e., a 50/50 ratio). The transition to the 75/25 ratio is scheduled to take place on October 1, 1985.

The move in 1984 from the 25/75 ratio to a 50/50 split between regional/national and hospital specific prices exacerbated some hospitals financial problems. Many institutions scrambled to adjust to the reality that a smaller portion of their payments was tied to past performance.

In response to the concerns of hospitals which were experiencing severe financial problems adjusting to the prospective payment system, the American Hospital Association (AHA) developed a DRG-specific price blending proposal in 1984. During Congressional FY 85 budget deliberations, AHA, in an effort to gain time for consideration of this plan, requested Congress to delay for one year the phase-in from the 25/75 ratio to the 50/50 split between regional/national and hospital specific prices. Congress did not consider AHA price blending proposal in 1984 and refused to delay the phase-in, largely due to the Reagan Administration's strong opposition to any delay in the transition schedule.

The Administration's FY 86 Federal budget proposal, and a subsequent Senate-White House budget compromise includes provisions which would freeze the FY 86 prospective prices at FY 1985 levels. While such a freeze in payments would adversely affect all hospitals serving Medicare patients, high cost hospitals will be particularly affected by the combination of the freeze and the scheduled move to the 75/25 split between regional/national and hospital specific prices.

In February 1985, a coalition of state and national hospital organizations was formed to seek a one year dealy in the transition. Representative Robert Matsui (D-CA), at the request of this coalition, introduced legislation (H.R. 1953) which would affect the delay. As introduced, H.R. 1953 propcses to delay the transition at the 50-50 split between hospital specific and regional/national payments for one year, or for as long as Medicare hospital payments are frozen. The transition from 50/50 to 75/25 would resume when Congress lifts the moratorium on payments. Resumption of the transition also would be tied to changes in the PPS on such issues as: severity of illness, the wage index, graduate medical education, regional disparities, and methodology regarding payments to disproportionate share facilities.

Representative Cardis Collins (D-IL) also has introduced transition delay legislation. Her bill, H.R. 2168 differs from the Matsui bill in that it would freeze the 50/50 split indefinitely.

Supporters of the transition delay advance several arguments as justification for the delay. Their major argument appears to be that if Congress freezes the overall Medicare payments to all providers, doing so should not subject the hospitals already penalized by the 50-50 payment rate to the additional financial impact that a move to the 75/25 level would provide. Consequently, transition delay supporters argue that for these hospitals a "bad situation should not be made worse."

The Alabama Hospital Association believes that although some of our nation's hospitals have experienced difficulty adjusting to the 50/50 split, the majority of hospitals have overwhelmingly responded to the new payment incentives under prospective pricing. This favorable response by hospitals which now operate more efficiently should not be disrupted with a transition delay, but should be rewarded with the scheduled move to a 25/75 rate.

Transition delay supporters also argue that certain regions of the country with lower cost labor should not be permitted to benefit from a move to the 75/25 level at the expense of some regions of the country which are faced with higher cost labor situations. It as inevitable that some hospitals with higher labor costs would seek some protection from the incentives of the system and call for a delay in the transition. Additionally, arguments are advanced that the intensity of care provided in certain regions of the country is higher than that provided in the low cost regions. However, this claim has yet to be substantiated with verifiable data.

Those seeking a delay in the transition argue that a delay at the 50/50 split would allow time to address perceived problems with the urban and rural designations. This argument was used during the FY 85 discussion of the transition issue as a justification for delaying at the 25/75 levels. The Reagan Administration has corrected urban/rural designation problems through the establishment of regional referral centers.

Moreover, in response to the special problems faced by rural hospitals, the Administration has greatly expanded its definitions of regional referral centers, thereby increasing flexibility in this area.

In addition, Congress has recognized the problem of the use of metropolitan statistical area designations and, in the Deficit Reduction Act of 1984 (P.L. 98-369) allowed for a three year transition for hospitals that were formerly designated as urban facilities to adjust to the transition to rural payment rates. The Association believes that the affects of P.L. 98-369 and the expanded use of regional referral centers will effectively rectify any discrepancies in the urban/rural designations, and believes, therefore, that no delay in the PPS transition is warranted.

Also raised during the FY 85 transition discussion were concerns with the application of the wage index. The Health Care Financing Administration (HCFA) submitted a report to Congress in March, 1985 that detailed a survey it conducted of all prospective payment hospitals on the wage index issue. Preliminary indications of the survey results show that the revised wage index's implementation will shift millions of dollars among the states. In fact, the new index will primarily benefit some of the same states which are currently calling for a transition delay.

Any delay would adversely affect those hospitals which have responded positively to the incentives inherent under PPS. Hospitals have responded by operating in a more efficient manner by controlling costs. Consequently, the government has dramatically slowed expenditures for Medicare, and the prospects for long-term financial stability of the Medicare program are brighter.

Prospective payment hospitals have based their upcoming strategic, competitive, and fiscal plans on the predictable shifts between the hospital-specific and regional/national rates. The system has allowed institutions to benefit financially from management efficiencies, and has enhanced their fiscal predictability. A transition delay would severely disrupt the necessary predictability for hospitals which have responded to the system in good faith. Clearly all PPS hospitals have had to modify their operating behavior, and, over the same amount of time.

It is the Association's view that any delay in the continuation of the phase-in would indicate to that Congress does not have any long-range intentions of using incentive-based programs to deal with health care financing. This signal will prompt some members of Congress to propose harsh regulatory hospital cost control legislation which will stifle innovative, cost cutting initiatives already under way. This signal will not be overlooked by the States and punitive state hospital cost containment legislation will proliferate as a result.

There exists little data indicating how higher and lower cost hospitals are responding to the incentives of the PPS. Clearly though, the scheduled transition phase-in has brought about noteworthy changes in the delivery of health care by our nation's hospitals. Full time equivalents (FTEs) are dramatically down from just a year ago. In that same time period, lengths of stays have been reduced nationally by over two days. Hospital productivity is at an all-time high. Most importantly, private and third party payers, as well as the Medicaid program, have all benefited from the effects of prospective pricing. Such successes are sure to multiply with the continuation of the phase-in. Any delay in the transition would surely disrupt the systems future positive effects.

Position.—With the likelihood of reduced payments, the importance of maintaining the incentives of PPS increases. Like a number of other state hospital associations the Alabama Hospital Association strongly supports the scheduled transition of the Medicare prospective payment system. As such, the Association opposes any effort to delay the move from the current 50/50 percent level of hospital specific and regional/national prices to the 25/75 percent level of hospital specific and regional/national prices.

IMPLEMENTATION OF THE REVISED AREA WAGE INDEX

Background and discussion.—The PPS payment amounts are adjusted to reflect wage levels in the Metropolitan Statistical Area (MSA) and non-MSA areas in the state. The Administration in formulating the PPS payments, used a national data base of hospital wage and employment records maintained by the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor. This data was recognized originally as being flawed substantially because of it's inability to recognize local differences in the number of part-time hospital workers.

Because the accuracy of the wage index can have a substantial financial impact on hospitals, the index values must be as accurate as possible. Through a joint effort between HCFA and the hospital industry, it was determined that the major drawback of the BLS data was it's inability to take into account differing part-time employment practices. A survey of PPS hospitals was conducted.

During the survey P.L. 98-369, the Deficit Reduction Act of 1984, was enacted. A provision of the law required the Secretary of Health and Human Services to conduct a study and report back to Congress. Additionally, the law required that changes for the area wage index be made retroactive to October 1, 1983. Hospitals which had been underpaid because of the original wage index would receive retroactive compensation. For those hospitals which had received overpayments because of the same index, a recovery would be required.

Subsequently, the report was delivered to Congress in March 1985. Essentially the HCFA report focused on the construction of two different wage indexes using the survey results. The first wage index was derived from total "gross" hospital wages, which includes salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians. The second index uses "adjusted gross" hospital salaries in the construction, i.e., salaries and wages of contracted labor, interns and residents, personnel employed in nonhospital cost centers.

The report does not make a recommendation as to which of the two revised indexes should be implemented, leaving Congress to decide which to use. While the report does not make a recommendation with regard to the retroactive application of a revised index, it appears that HCFA prefers that the retroactivity requirement be dropped. HCFA seems to prefer that any corrections to the wage index be done when the F.Y. 86 PPS rates go into effect on October 1, 1985.

Position.—AlaHA feels that the gross wage index should be utilized because of it's recognition and measurement of the differences from area to area in gross hospital wages. In the HCFA survey, hospitals had extreme difficulty in determining the wages, salaries, and hours worked for excluded worker categories used to develop the adjusted gross wage index. Thus the adjusted gross index is likely not to be as accurate as the gross wage index would be in measuring direct wages.

Even though preliminary AlaHA data indicates that Alabama hospitals, as a whole, will be hurt financially by an adjustment to the wage index using the gross index, it is the Associations view that if the data was initially wrong, as he has been indicated by the survey, it should be corrected when the new F.Y. 86 rates are implemented. Improving the accuracy of the wage index is of paramount importance. Due to it's inaccuracy, some hospitals have received reduced payments for two years. This correction should occur as soon as administratively feasible.

Because PPS is by law "budget neutral", application of the wage index will be wholly redistributive. Due to the delay in completing the survey and report, two years have elapsed since Congress legislated a retroactive application for a revised index. After two years it is unreasonable to go to hospitals and seek recoupment. AlaHA strongly opposes the retroactive application of the wage index and urges Congress to amend the law to delete the retroactive application requirement.

RETURN ON EQUITY

Background and discussion.—Capital related costs are currently excluded from the PPS until October 1, 1986. Capital-related costs, including return on equity for proprietary hospitals, depreciation, leases and rentals, and interest, are thus treated as a passthrough on a reasonable cost basis.

The Secretary of Health and Human Services was required to report to Congress within eighteen months of enactment of the PPS system on methods by which capital costs could be included in the rates. This report was due to Congress in October 1984. Medicare payments for capital costs are prohibited after September 30, 1986, unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

For capital to be realistically reflected in a hospital's price, some basic principles must be recognized. First, all capital has a cost. Secondly, hospital's costs are composed of the two basic elements of: a return of capital, or the cost of consuming capitalized assets or the depreciation expense intended to replace the capital invested, rather than the assets themselves; and return on capital, or the cost of using money, whether from debt or equity sources, coming from retained earnings as well as stockholder or philanthropic investments.

Position.—Because of the significance of the capital issue to all types of hospitals, Congressional decisions about how all capital, including return on equity, is to be treated under PPS should be made with the utmost of care. The treatment of all capital-related issues should not be considered only as strictly deficit reduction options. Without the benefit of the Administration's report on capital, it appears imprudent for Congress to act at this time in singling out such an important and interrelated capital component as return on equity.

The AlaHA urges Congress to delay making any decisions relating to capital, including return on equity, until it has received the Administration's report, and has had the opportunity to conduct hearings on the issue. Congress should develop a rational approach to handle this important issue. That approach should be consistent with traditional business practices used in other competitive environments.

FREEZING DIRECT MEDICAL EDUCATION PAYMENTS

Background and discussion.—Since its implementation, Medicare has shared in hospitals costs for training doctors, nurses, and allied health personnel. The proposal to freeze direct medical education payments, would affect hospitals which receive Medicare reimbursement for costs of these educational programs. Direct costs include interns and residents salaries as well as classroom and other overhead expenses.

At the present time, there are 82 hospitals in Alabama which for F.Y. 1984 received approximately $9 million based on the current Medicare payment criteria for the training of physicians, nurses, and allied health personnel.

Hospitals experience some confusion and difficulty as they try to identify all costs associated with their educational activities. These activities, due to the absence of recognized guidelines to define acceptable appropriate costs.

There are two distinct public policy benefits of direct medical education payments. First, Medicare recognizes resident care of beneficiaries as a hospital cost. Thus residents are not allowed to bill Medicare Part B on a fee basis. While this does increase Part A costs this policy has been demonstrated to be of overall savings to the Medicare program. Secondly, while today's Medicare beneficiaries are receiving quality treatment, an ample supply of highly trained health care professionals for the future is being assured. Both of these benefits are worthwhile.

It is logical to assume that if the Administration's proposal to freeze direct medical education payments to hospitals is implemented, hospitals which serve primarily sicker patients and have a substantial load of indigent patients, would be forced to curtail services. Graduate medical education cannot function effectively unless teaching hospitals are compensated for the added costs associated with their responsibilities.

Position.—The AlaHA urges Congress to develop appropriate guidelines for the recognition of hospitals educational costs. Congress also should recognize the societal benefits of the payments now and for the future. Additionally, any payment policy in this area must recognize the distinctive characteristics and diversity of teaching hospitals. AlaHA urges Congress to act carefully as it considers the proposed freeze on direct medical education payments, and to develop a rational Medicare policy recognizing a hospital's teaching costs.

CONCLUSION

The Alabama Hospital Association sincerely appreciates the opportunity to present its views on selected issues relating to hospital payments under the Medicare program. Specifically, we recommend:

That Congress adopt the PROPAC recommendation for a F.Y. 86 PPS rate of increase, of between one and three percent.

That the transition continue as Congressionally mandated;

That the gross area wage index in HCFA's recently released report be instituted effective for October 1, 1985.; and, that Congress repeal the retroactive requirements of the application of the revised wage index.

That Congress refrain from action on the issue of eliminating return on equity until a rational and comprehensive policy for the treatment of all hospital capital costs is developed; and

That Congress act carefully in its consideration of direct medical education costs, and develop a rational Medicare policy which recognizes hospitals costs for medical education.

Thank you Mr. Chairman. I would be pleased to answer any questions which you and other members of the Subcommittee may have.

RESOLUTION: SUPPORT FOR THE SCHEDULED MEDICARE PPS TRANSITION

We, the undersigned representatives of the hospital industry in our respective states, wish to go on record as supporting the scheduled transition of the Medicare prospective payment system (PPS). We oppose any efforts that would delay the move from the current 50/50 percent level of hospital specific and regional/national prices to the 25/75 percent level of hospital specific and regional/national prices.

We believe that the prospective payment system's design to reorient hospital incentives has been overwhelmingly successful. Full time equivalents (FTEs) are dramatically down from just a year ago. In that same year, lengths of stay have been reduced nationally by over two days. Hospital productivity is at an all time high. The prospective payment system has also fostered long-term financial stability for the Medicare program. Besides saving the federal government billions of dollars, the prospective payment system has benefited third party and private payers, as well as beneficiaries in the Medicaid program.

Fiscal predictability for hospitals was one of the cornerstones of the prospective payment system. Stopping the transition will severly disrupt the necessary fiscal predictability for hospitals, which have responded to the system in good faith. Such a delay will prompt some members of Congress to propose harsh regulatory hospital cost containment legislation which will stifle innovative, cost cutting initiatives already under way. Such action will not be overlooked by the States, and punitive state cost containment legislation will proliferate as a result.

We urge you to strongly oppose all efforts to delay the scheduled Medicare prospective payment transition.

Chairman **STARK**. Let me start with you, Mr. McDougal. And I make this assumption, and I gather it really hasn't been challenged: Why are identical procedures so much more expensive in California than they are in Alabama? What one or two factors? It can't be wages.

Mr. **McDOUGAL**. Wages are part of that. I think there are also differences in staffing patterns, differences in perhaps the market baskets in those areas that would constitute some of that. I think that the different hospitals even in my part of the country have responded differently historically to the availability of cost reimbursement.

What we have done is go toward quality in the name of unlimited ability to spend. And now what we are trying to do is come back and redefine what is quality and what is that minimum standard. I think that different organizations have responded differently on that.

Chairman **STARK**. That sure doesn't bail me out.

Of the factors you raise, take a common, not-too-critical procedure, what do they do more than appendectomies any more these days?

Mr. **McDOUGAL**. On an inpatient basis?

Chairman **STARK**. Yes; that you still do on an inpatient basis.

Mr. **McDOUGAL**. The appendectomy is probably appropriate. I really think it——

Chairman **STARK**. Why should it cost three times more in California than in Alabama? Do you receive lousy care in Alabama and excellent care in California; three times better? Doctors are probably making three times as much. That seems to be, but that doesn't add to the DRG.

Mr. McDOUGAL. I wouldn't certainly guess the quality of care is three times better. I think the quality of care in Alabama hospitals is very good.

Chairman STARK. I am sure.

Mr. McDOUGAL. It can only be explained away by, I think, history. It was much of the history that caused this Nation to lean toward a prospective pricing system linked to a national rate that over time, with appropriate phaseins and incentives, would begin to sort out the inequities and differences that are there.

Much of it has to be attributable to the practice of medicine in certain areas of the country, utilization, et cetera. This system is designed to find those, and where there is legitimate additional cost it ought to be dealt with, and ought to be dealt with appropriately, as it is identified.

Chairman STARK. OK. Thank you.

Mr. Norling, do you believe that the 50-50 split is exactly where we ought to be, or would you pick a different percentage?

Mr. NORLING. No, sir. I believe the 50-50 split is where we ought to be right now, because I think that——

Chairman STARK. What about prospectively, over the next few years?

Mr. NORLING. I believe we ought to move toward a national system, preferentially through the AHA price blending, which reflects those procedures that are commonly performed in California and Alabama as compared to those that are performed differently, for a variety of reasons.

I would like to add to Mr. McDougal's differences.

Chairman STARK. Don't you think it would be a better idea to try to resolve the problem with the best compromise we can work out; and if the freeze is necessary, to make it a transition rather than ignore the problem for another year?

Mr. NORLING. I would believe a pause is necessary to allow the time to truly solve the problem. I think there are a lot of issues that require research. Such research is either not done or is awaiting presentation.

Chairman STARK. Let me just back up. You saw the figures presented with the hospital panel. Are you comfortable with those absent any great addition from HCFA?

Mr. NORLING. With respect to uncompensated care, yes, I am.

Chairman STARK. Generally, though, do you think the data is available which you and I and Mr. Gradison and whoever else wants to get into the boxing ahead without HCFA which would resolve these problems? Do they have any secrets over there that you think are important to your case?

Mr. NORLING. I am certainly no expert on HCFA, sir. But I think particularly in the area of the disproportional share institutions there is more than adequate data to go ahead.

Chairman STARK. How about to get to proper transition, proper national rate; do we have data to do that?

Mr. NORLING. I don't believe so.

Chairman STARK. What do you think is missing?

Mr. NORLING. I think especially the issues on severity of illness, variation within the DRG respecting utilization of resources, et cetera.

Chairman STARK. You know what that is in your region, don't you?

Mr. NORLING. Actually, I don't, although I am very specifically aware of the issue with respect to my institution.

Chairman STARK. How about the institutions in California? How long would it take to get the data in California? Overnight? Two days?

Mr. NORLING. I believe it is more in terms of months, and it is achievable and resources of the institution are available.

Chairman STARK. How about Mr. McDougal? Could Alabama come up with that information pretty quick?

Mr. MCDOUGAL. Yes, sir. I think we could provide that quickly.

Chairman STARK. Obviously, I am trying to build the case that the freeze seems only half a loaf. While that may well be an appropriate place to freeze or pause or whatever you want to call it, I repeat my feeling that this committee wouldn't really be doing its work otherwise.

I make no brief for allowing the 75 percent to pop up on this. It seems to me that was the law. It seems you guys knew it was coming. I know you had a pass last year and no one went broke then. But having failed last year, it seems to me everybody had a year to come up with numbers. I guess that is what bothers me.

Given the year, all we have heard is freeze. Were I running your association, I might have been spending that year preparing an alternative. It is easier, as with a candidate, to present an alternative rather than being just negative in politics.

I hope that while you push for the freeze, you will help us try to find the answer. We have heard a lot of testimony that there ought to be changes in the PPS as we approach the national rate. I certainly don't have the knowledge to disagree with any of the experts we have heard today, and I think there will be some difference of opinion. I am not sure what is best for Alabama is best for California, but I am sure we will have to compromise.

It is a whole lot easier to do that when we have some numbers than just to keep pushing and fudging and shoving until we have 50 percent of the votes plus one and say stop there. That is one of the battles.

I hope you will join with us in this committee as we prepare the agenda whereby we can resolve the problem, and not only if the pause is necessary—have the pause—but make the pause a determinant length leading to a program that will have more universal support than the present one.

Mr. NORLING. Yes, sir.

Chairman STARK. Mr. McDougal.

Mr. MCDOUGAL. The one thing I fear, Mr. Chairman, is you may still not have, once you get specifically what you have asked us for, the real comparative data as to how different hospitals, different regions, and States have responded to the incentives of the system; the reduction of absolute employment, what was good to begin with and what should it be now. Those things, in my opinion, can only be sorted out once you have gone into the system—through the system—and then see in fact what happened.

Chairman **Stark**. I think I agree with you. What you are saying is one of the ways to see what will happen with the system is get on with it and then let's make adjustments after we go ahead. Regardless of what comes out, we will have to do that.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I wonder if each of you could give us an answer to this question: Is the opposition toward taking the next step to the national rate unanimous among your members?

Ohio?

Mr. **Wilburn**. I doubt that anything is unanimous. There have been a lot of discussions among the board members of the OHA, and I would say there is by far a preponderance but not unanimous, no.

Mr. **Gradison**. I understand that. OK.

How about Illinois?

Mr. **Oder**. I doubt also that anything is unanimous. The hospitals in Illinois, about 81 percent of them lose reimbursement by moving to the national rate. Certainly, it is the policy of the State and the board of the association is that, but there has not been a poll of the members.

Mr. **Gradison**. California?

Mr. **Norling**. Roughly the same as Illinois. Eighty percent are losing.

Mr. **Gradison**. Eighty-twenty.

Mr. **Norling**. And I would think a substantial remainder of them would accept the association policy.

Mr. **McDougal**. I am not sure they agreed on hiring me, Mr. Gradison.

Mr. **Daub**. Five to four, huh?

Mr. **Gradison**. I know a lot of Ohioans did agree on hiring me, so I know what you are saying.

Mr. **McDougal**. Our position is a unanimous feeling of the board of our association. We have given wide publicity to not only this position but also the position we took in the American Hospital Association Regional Advisory Board where we introduced a resolution to this effect, and I have heard no opposition from member hospitals. I am sure there are some who don't agree with it, but have accepted that position.

Mr. **Daub**. Would the gentleman yield?

Mr. **Gradison**. Of course.

Mr. **Daub**. Because I have to leave to go to a social security meeting I just want to thank Mr. McDougal in particular for his work with my staff and his magnanimous gesture regarding the wage index. I also want to indicate that indeed we will be working with you to try to do something about that. And I just appreciate that very much.

In addition, I have read the testimony of the two remaining witnesses, and I think they will offer a great deal to our record, as well.

Thank you for yielding, Mr. Gradison.

Mr. **Gradison**. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, we are flogging this dead horse about the transition rates, and I guess they are a very important subject. It seems to me the purpose of establishing a national rate is to arrive at a fair rate across the country. The DRG won't work. We have to have a national rate. Nobody disagrees with that.

HCFA has been trying to arrive at what would be the right figure. They have looked at this for 3 years now, and they have decided starting up soon we would have this national rate. I don't know if that is the right rate. But it seems to me the presumption should be that it is.

Most of you who have testified indicated you need another year's delay. Now, we haven't rushed into it for 3 years now. I got a feeling if we have 1 more year delay, you will say, well, we found very interesting facts and we need another year delay. I think that will go on and on. That is a personal opinion.

We ought not jump into things and be unfair, but if we hold off after considerable study and we reach a national figure, it would seem to me that we probably ought to proceed with it unless you have some reason to show it would work a great hardship. If it does work a great hardship, I would ask why is your cost that much more than my State. Either you give a lot of extra costs or we furnish very important health care.

Maybe it is a combination. I don't know which. That is what we are trying to sort out now.

I got a feeling, though, that HCFA is trying to arrive at what they think is a fair figure. I would hope we proceed with that approach.

Thank you.

Chairman STARK. I want to thank the panel very much. We appreciate your testimony.

Our final panel is: William J. Cox, vice president, Government Services, Catholic Health Association; and Brian Lockwood, president, Combined Health Resources, American Protestant Health Association.

Welcome. You represent what I, as a little boy, thought ought to be running hospitals. But I understand the world has changed a great deal on that in that half-century.

Would you proceed, then, Mr. Cox?

STATEMENT OF WILLIAM J. COX, VICE PRESIDENT, DIVISION OF GOVERNMENT SERVICES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, ACCOMPANIED BY DENNIS BERRY, COUNSEL

Mr. COX. Thank you, Mr. Chairman.

Joining me in the room today is Dennis Berry of the firm of Wood Young Singer & Epstein. Mr. Berry's firm is counsel to the Catholic Health Association on the issue of improving the appeals processes for beneficiaries and providers of the Medicare System, and he would be happy to answer any technical questions that you or members of the subcommittee may have on that question.

You have a copy of our complete testimony in front of you, and I would just like to make a few brief points in my time this afternoon.

First of all, we would like to go on record before this subcommittee as being in strong support of the transition delay. It is important to recognize that one of the primary purposes of the PPS was to provide hospital administrators with a very strong incentive to get costs down and keep those costs down and possibly earn a profit in the process of doing so.

For a price system like that to work, it has to recognize and take and adjust for costs outside the administrator's control. We think this is in the latter area, and there was a lot of evidence provided earlier by other witnesses providing support for that point of view.

With respect to our support for a delay in the transition, we do it in the context of complete support for the prospective payment system. This is a national pricing system. This type of regulatory initiative is a fragile one by definition, and that for it to continue to operate effectively it must enjoy the broad support of the people that are being regulated by it.

When you have a majority of the hospitals in States the size of California, Illinois, Ohio, Michigan, Wisconsin saying that they are being paid unfairly under this system, then I think the system is in jeopardy, quick jeopardy, of losing its morale, and political support in the Congress. Delay the transition to national rates, make adjustments that are needed, and then continue on toward national rates if the Congress feels that is justified. In that sense, I think the delay is not the first nick in the armor of prospective payment but rather a mechanism for or device for maintaining support for the PPS into the future.

A couple of other issues. We want to go on record, as other witnesses have today, in support of the disproportionate share issue. Many of our hospitals are in large urban areas and have disproportionate share problems. There is a difficulty, I understand, in defining disproportionate share hospitals, in coming up with appropriate proxies for measuring low income patients. We would be happy to work with the committee with respect to addressing those two questions. We don't have any answers today for them.

We want to go on record also in support of revised or an improved appeals process under medicare for both beneficiaries and providers. Congress has not paid systematic attention to this issue for at least a decade, and we think in that period of time there has been a virtual revolution in the way the Government pays hospitals under the Medicare Program. And with the growth of the Prospective Payment System and development of PROs, we think beneficiaries' and providers' appeals need special attention by the committee.

With respect to one final issue, I would make one last point, and that is in the area of capital. And while it is not before the subcommittee as a point on the agenda today, I would like to say I am concerned about it because there are growing reports in the trade press that the hospital industry is in support of doing something on folding capital into the prospective rate this year and possibly doing it as part of the budget process.

I would like you to know that the Catholic Health Association would be opposed to taking any action on capital this year. We think it is probably one of the most controversial issues within the hospital community generally, and there is no special urgency to taking action right away.

Given those two facts, we think that hearings would be appropriate this year with a view of possibly taking action next year.

With that, I would—

Chairman STARK. What was so much better next year than this year? It is an election year. We never do anything courageous in even-numbered years.

Mr. COX. It is an especially complex issue, even more so than developing prices on the operating side for hospitals. From a budgetary point of view, I think it is of less importance to the Federal Government than it is to individual hospitals because of the range in capital spending by hospitals. It is an issue that deserves very special attention before the committee acts.

That concludes my statement, Mr. Chairman. I would be happy to answer any statements.

[The prepared statement follows:]

STATEMENT OF WILLIAM J. COX, VICE PRESIDENT, DIVISION OF GOVERNMENT SERVICES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Good morning. I am William J. Cox, Vice President of Government Relations of the Catholic Health Association of the United States (CHA). The Catholic Health Association is an association of hospitals and nursing homes sponsored by religious orders and dioceses of the Catholic Church. As a national association it represents 627 member hospitals and 288 long-term care facilities.

I am grateful for this opportunity to appear before you to testify on the issues relating to Medicare hospital payments. My testimony will address the following issues: The impact of continuing the transition to national rates in combination with the Administration's proposed hospital Medicare rate freeze, the importance of delaying the transitiion especially under "freeze" conditions, and the value of recognizing the special needs of disapportionate share hospitals.

I will also share with you CHA's views on: Including hospital capital costs in Medicare's prospective payment system, and improving appeals procedures available to Medicare beneficiaries, providers, practioners and suppliers.

THE CATHOLIC HEALTH ASSOCIATION SUPPORTS PROSPECTIVE PAYMENT

However, before I begin I would like to reiterate CHA's support for the Medicare prospective payment system.

The Catholic Health Association strongly supports the Medicare prospective payment system (PPS). Accordingly, we are desirious of working with the Congress, the Administration and others to make the program a success. As it is currently structured, however, the system is not yet on the firmest ground from a methodological and data point of view. It must be remembered that PPS is still relatively new and will require extensive fine tuning before it can be expected to fairly and equitably pay America's hospitals for the services they provide the nation's elderly and provide all hospitals with an appropriate incentive for efficiency. Unfortunately, the President's fiscal year 1986 Medicare budget proposals address none of the program's systemic difficulties and, if adopted, will only serve to weaken it further.

The federal government currently uses four factors to adjust the PPS rates to account for cost per discharge differences between hospitals. Those factors are the area wage adjuster, the DRG weights, the indirect medical educational adjustment and the annual update factor. From the inception of the PPS program, the accuracy and reliability of each of these factors has been called in to question.

For instance, the wage index has been criticized for not being sufficiently reflective of the differences in hosptial labor costs from one locale to another. While the Department of Health and Human Services took early action to correct this situation, and has, in fact, submitted a report to Congress, implementation of the revised index is in doubt as its use would cause a substantial redistribution of Medicare dollars among regions of the country.

The DRGs themselves have also come under considerable criticism. A number of analysts have criticized the DRGs for not being sufficiently sensitive to the severity of illness. Others have criticized the DRG weights for overvaluing simple cases such as tonsillectomies and undervaluing more complex cases such as open heart surgery. There are a number of additional constructive criticisms that have been identified by the Prospective Payment Assessment Commission (ProPAC) and have beem recommended by ProPAC for further study.

The medical education adjustments have also been called into question. During the 1983 debate over prospective payment Congress and the Administration doubled the indirect teaching adjustment. The teaching adjustment was doubled to account for factors that are believed to make teaching hospitals more costly than nonteaching hospitals. At the time, it was speculated that many of these costs were associated with sicker patients, more costly technology, the cost of residents and higher indigent patient loads. It is important to emphasize here that while little more is known today about what causes teaching hospitals to be more expensive than nonteaching facilities, the Reagan Administration has nevertheless proposed that the teaching adjustment be reduced by half; and it has made this recommendation in the absence of any research-based justification for doing so.

The hospital market basket is supposed to measure the annual increase in costs of the goods and services hospitals must buy in order to deliver patient care. Shortly after the Prospective Payment Assessment Commission convened, it questioned the accuracy of the market basket. As part of its report to Congress, ProPAC has recommended further study of the market basket.

It should be obvious that much more work needs to be done with respect to improving the accuracy and reliability of the PPS adjustment factors before all providers will feel confident that the program treats them fairly and equitably. Should PPS loose provider confident and, therefore support, the program might well collapse.

PPS FREEZE UNFAIR

The President's proposal to freeze the PPS rates, rather than making a necessary contribution to the long term stability of the PPS program, only serves to weaken it. Furthermore, the proposed freeze completely ignores the better than expected progress America's hospitals have been making over the past few years in terms of reducing Medicare expenditures. Back in 1983 the federal government projected that under the new prospective payment system, it would pay $42 billion for hospital services in FY 1984; however, actual expenditures were $39 billion—a full 7 percent below government estimates!

As the PPS program was being debated, the government conveyed the clear expectation that on an annual basis the Secretary would examine the need to raise the PPS rates and in so doing would take into consideration the increase in input prices to hospitals as measured by the hospital market basket.

The Administration contends that under a strict reading of the statute the Secretary has the authority to freeze the PPS rates without congressional approval. Such an interpretation may be in keeping with the letter of the law but it certainly shatters the spirit of the agreement between providers, Congress, and HCFA/HHS when prospective payment was enacted.

It also bodes ill for the future of PPS with respect to the kind of cooperation that must exist between providers and the government in order to keep the program going.

PROPOSED PPS FREEZE AND THE TRANSITION TO NATIONAL RATES

The White House proposed freeze while unfair to all hospitals would be especially hard on those facilities whose specific costs are higher than the natioinal PPS prices. (It should be noted here that Medicare may underpay such hospitals due to the deficiencies in the PPS adjustment factors noted above as well as for other reasons outside of hospital management control and not identified here.) As PPS moves away from hospital specific rates and toward national rates, many of these hospitals will experience a substantial net reduction in PPS price per discharge from one year to the next rather than a net increase reflective of increases in the hospital market basket. For such hospitals a freeze in the PPS rates is more than just unfair, it is wholly unreasonable.

The attached chart graphically illustrates the harsh effects on an actual hospital (hospital A) as it enters the PPS program in October 1983 and faces the likelihood of both a freeze in its Medicare rates and a continuation of the movement to national PPS prices. (The example cited here is based on the actual experience of one hospital in the East North Central region. This hospital's experience is shared by many other facilities in this region as well as other regions of the country.)

When the hospital entered the Medicare prospective payment program in 1983 it had an average cost per discharge approximately $2,000 above the national PPS rates. In order to bring its average Medicare cost per discharge under the Medicare PPS payment per discharge it would have to cut its cost in year one by 9.8%. In the second year, the hospital would have to cut its cost by another 6.4%.

If in the third year of PPS (a) no freeze is imposed, (b) the hospital market basket is applied and (c) the transition is continued the hospital would have to reduce its costs by another 7.3%. Alternatively, if there is a freeze in the rates but not in the transition to national prices, then the hospital will have to cut its cost by a whopping 13.5%!

The impact of a freeze is even harsher on these hospitals when a comparison is made between how such hospitals are likely to perform relative to the hospital market basket over the same period of time. Between Oct. 1, 1983 and Sept. 30, 1986, the hospital cited in the example will have to cut its cost by 21.7%, if there is no freeze and the market basket plus .25% is applied. If there is a freeze it will have to cut its costs by 26.9%.

It is also important to emphasize that many hospitals that would experience the excessive downward effects of both freezing the FY 86 Medicare payments and continuing the transition to national prices might also have to cope with substantial cuts in direct and indirect medical education payments. The combined impact would be enormous.

Contrast the experience of hospital A with the substantially different experience of a facility in another census region (hospital B) that at the start of PPS on Oct. 1, 1983 had a hospital specific cost per discharge $1000 below the estimated national average urban rate.

The chart clearly shows that increases in the PPS rate along with the dynamics of the phase-in increase hospital B's rate substantially in excess of the hospital market basket.

Freezing the PPS rates in FY 1986 and continuing the transition increases this hospital's revenue per discharge by 11.8% over the previous year.

Freezing the PPS rates and the transition at their FY 85 levels would allow this hospital's revenues per discharge to exceed its Oct 1, 1983 hospital cost per discharge trended forward by the hospital market basket by 12.5%

As this Subcommittee struggles with the FY 1986 Medicare budget it will find no easy or pleasant choices. Nevertheless, I hope this chart makes it clear that if Congress enacts a freeze in the PPS rates or allows the Secretary to impose a freeze in the PPS rates, then the transition ought to be frozen at 50% hospital specific and 50% regional/national payment. The latter portion of the payment ought to be frozen at 75% regional rates and 25% national rates for at least the period the freeze is in effect.

As Congressional Budget Office (CBO) data as well as other data make clear, the full implementation of national PPS prices will result in large redistributions of Medicare dollars from hospital to hospital and region to region. Such redistributions have the potential for creating unintended but serious problems with the quality and accessibility of health care services in certain areas of the country.

Accordingly, the Subcommittee should give serious consideration to recommending a delay in the transition at 50 percent hospital specific and 50 percent regional/national prices until HCFA and others, including the hospital sector, have had a sufficient opportunity to analyze the cost report and other data (or an adequate sample of that data) for the first year of PPS operational experience.

Such analyses and experimental data would make it possible to identify potential undersirable outcomes of the tremendous redistributions of Medicare monies which result from full implementation of PPS. Once such problems are identified appropriate solutions can be designed and implemented.

HELP DISPROPORTIONATE SHARE HOSPITALS

CHA vigorously supports the disproportionate share concept and applauds the attention this Subcommittee, its members and its staff, have given the issue year after year since 1981. As the members of the Subcommittee are well aware the disproportionate share concept has been part of the Medicare statute since the Omnibus Budget Reconciliation Act of 1981. As provided for in Section 1886(d)(5)(C)(i) of the Social Security Act, the Secretary of HHS is to provide for an adjustment to PPS for hospitals that serve a disproportionate share of low income people and Medicare patients.

The District of Columbia Hospital Association and HCFA have performed analyses of the correlation between the proportion of low income patients and Medicare cost per case. Each of the studies demonstrated that there was a statistically significant positive correlation between proportions of low income patients and higher Medicare cost per case. These studies justify an adjustment for disproportionate share hospitals.

Yet despite Congress' repeated support for such an adjustment and the studies cited above, the Department of Health and Human Services has steadfastly refused to take appropriate action.

It is now clear that if the disproportionate share adjustment is to be implemented Congress will have to design and statutorily require its implementation.

There are a number of questions that are involved in the design and development of a disproportionate share adjustment package. They include but are not limited to: Measurement of disproportional share of low income patients, establishing the point at which a hospital would become eligible for the adjustment, deciding whether the adjustment ought to be granted automatically or an application should be made to the Secretary.

At this point, I would like to share with you our thinking with respect to each of these questions.

Measuring the impact of low income patients and Medicare costs has presented many problems to researchers. Because there is no income data in the government or private sector claims data, previous studies and efforts to better understand this issue have relied on imperfect proxy measures such as hospital's proportion of Medicaid patients. CHA realizes that there may not be currently available a precise way to measure disproportionate share. However, we believe that the issue is important and critical enough that Congress should accept the best proxy available and proceed this year with the design, development and implementation of a disproportionate share adjustment package.

Determining the criteria to be used for identifying disproportionate share hospitals is critically important. For instance, should a hospital become eligible for a disproportionate share adjustment when its low income and Medicare patients as a proportion of its total patient population exceed the national average or should the point of eligibility begin at some point substantially above the national average, i.e., once or twice the standard deviation from the mean or two times the national average? Establishing the point of eligibility substantially above the national average would limit the application of the adjustment to only relatively few hospitals (and most probably one, perhaps two hospitals in each metropolitan area).

These are important considerations. For instance, an overly narrow definition of disproportionate share hospital might inadvertently increase rather than ameliorate the problems of the hospitals so designated. This could happen by causing such hospitals to be targeted for increased "dumping" of low income patients since they have been "officially" designated by the government as disproportionate share facilities and receive an extra Medicare payment. CHA believes that such a result would be an inappropriate and unfortunate outcome to this important issue.

Therefore, CHA is currently in favor of establishing the point of eligibility at the national average. For every percentage point by which a hospital's percentage of low income and Medicare patients exceeds the national average, the hospital would receive an adjustment to the PPS rate reflective of the incremental cost associated with taking care of low income and Medicare patients.

CHA believes that the application of the adjustment ought to be automatic, somewhat akin to the teaching adjustment under TEFRA and PPS.

After these and other questions are resolved, CHA believes that Congress should write the legislative language involved with such specificity that the adjustment provision is literally self-implementing at a date certain.

CAPITAL COSTS

The PPS statute requires Medicare to include capital costs in the prospective payment system by Oct. 1, 1986; or in lieu thereof to require nationwide Section 1122 planning.

HHS was required to deliver to Congress by Oct. 20, 1984 a report as to how capital costs could be included in Medicare prospective payment. HHS has not yet submitted that report. However, it is expected to submit its report at any moment.

The most likely HHS proposals that have been mentioned so far are: a percentage add-on to PPS rates of 7% or 7.4%; and "total revenue proposal" which would use

1981 and 1982 Medpar data and cost report data inclusive of capital cost data to recalculate the DRG weights and PPS rates; even if this methodology were to be used the total capital dollars to be included in the PPS rate would not meet or exceed 7.4% of operating cost.

There are strong indications, including several reports in the hospital trade press, that some providers' representatives and some officials in HHS are suggesting that some method of adding capital to Medicare's prospective payment system be included in this year's federal budget legislation. CHA would strongly oppose any such effort.

We believe that the issue of including capital costs in PPS is so complex and the ramifications so far-reaching that the hospital sector and others effected by this decision should be given ample time to analyze and determine the impact of any such proposals.

The issue of capital is so important to the welfare of the nation's health care delivery system that once a proposal is made public, the hospital sector should be given sufficient time to design and conduct a survey of its hospitals to assess the proposal's impact.

Nevertheless, CHA believes that it would be extremely beneficial if Congress began hearings on the capital issue this year.

APPEALS PROCEDURES

It has been 13 years since Congress last made a thorough examination of Medicare appeals procedures and procedural protections.

This year, CHA encouraged a broad-based coalition of beneficiaries, providers, practitioners and suppliers to review the Medicare appeals procedures. These groups have come to believe that the currently configuration of Medicare appeals and procedural protections work to the overwhelming and unfair advantage of the Department of Health and Human Services. This coalition is now supporting a package of amendments which would offer solutions to the problems identified. Among the areas covered by this package of amendments are:

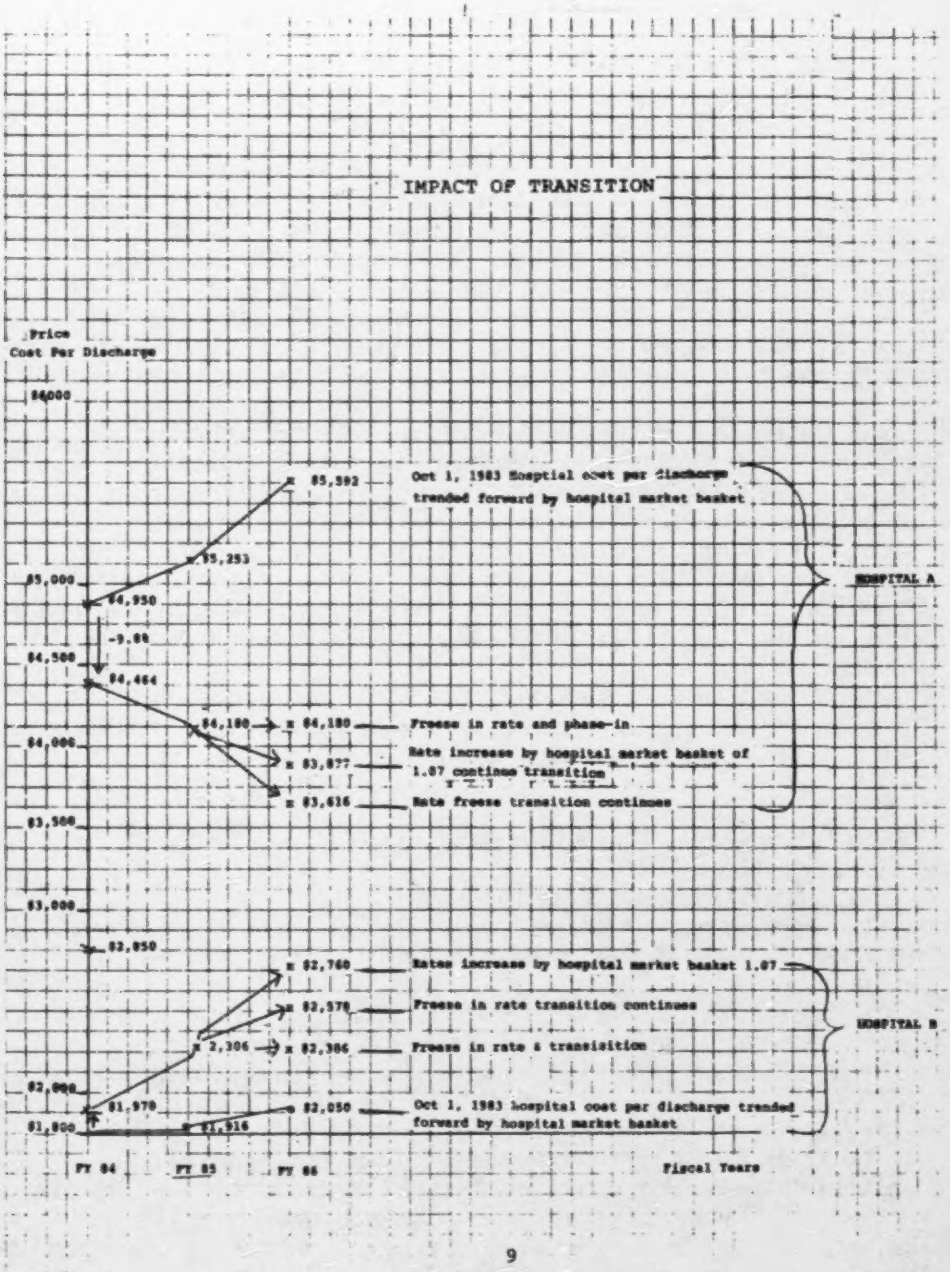
Increased protection for providers, beneficiaries and the program in the areas of early discharge and denial of admission which will become an increasing problem as HCFA/HHS moves to eliminate the "favorable presumption" in waiver of liability for hospitals, nursing homes and home health agencies.

Solutions to problems that beneficiary groups have had with the Part B appeals process since Medicare began. These amendments would also offer providers, practitioners, suppliers and beneficiaries access to an administrative law judge (ALJ) and judicial review of ALJ decisions of Part B claims. This is particularly important now that so much of the health care for the elderly is following the incentives created by Medicare's PPS and shifting to modalities of care covered by Part B.

Due process and procedural protections from certain adverse PRO decisions to beneficiaries, providers, etc. Currently, a beneficiary may not appeal an adverse PRO decision to a higher level, nor may a provider.

Improved procedural protections for beneficiaries, providers et al.

Mr. Chairman, that concludes my formal remarks this morning. I would be happy to answer any questions.



IMPACT OF TRANSITION

Chairman **Stark**. Thank you very much.

Mr. Lockwood.

STATEMENT OF BRIAN C. LOCKWOOD, PRESIDENT, COMBINED HEALTH RESOURCES, PHOENIX, AZ, ON BEHALF OF THE AMERICAN PROTESTANT HEALTH ASSOCIATION

Mr. **Lockwood**. Yes, Mr. Chairman, Mr. Gradison, I am a past chairman of the American Protestant Hospital Association, and currently I am president of Combined Health Resources of Phoenix, AZ, a multi-hospital system of not-for-profit hospitals.

The APHA appreciates the opportunity to present its views on the critical issues related to the Medicare PPS which I want to be sure you understand we strongly support. We commend the subcommittee on holding hearings to examine this important issue in depth.

You have spent a substantial amount of time in hearing a lot of testimony and rather than reading my entire testimony, I would like to make a few points which have been alluded to earlier.

Chairman **Stark**. Please.

Mr. **Lockwood**. Assuming a freeze in the payment rate, we oppose the transition; instead a 1-year freeze is proposed in that transition. We are not married to that 1-year freeze. What we believe, is there has to be time to deal with the issues you discussed earlier.

Chairman **Stark**. If we don't freeze the rates, how much do we have to give to get you to back off that position, from zero to five? Will you be happy if we continue the transition and give you 2 percent?

Mr. **Lockwood**. No.

Chairman **Stark**. Two and a half?

Mr. **Lockwood**. No.

Chairman **Stark**. Am I getting close?

Mr. **Lockwood**. As you are aware, ProPAC recommended a 1- to 3-percent increase in the payment rate.

Chairman **Stark**. Yes.

Mr. **Lockwood**. However, the administration chose not to wait for the recommendations before proposing a freeze.

Chairman **Stark**. What if we give you the three, would you back off?

Mr. **Lockwood**. I think we would feel a lot better with that.

Chairman **Stark**. You won't worry about the freeze then?

Mr. **Lockwood**. We would feel better about that because that was what ProPAC was put in place for. The concern about the freeze is the very things I believe, when this program was being discussed in the Senate, Senator DeConcini and Senator Durenberger had comments about that, which is in my testimony.

Those are the things we are concerned about. I know you and the administration are concerned about increasing the case mix. We believe the reasons for the increase now is that we are treating sicker patients. We offered to work with the administration to resolve this issue. Last summer they agreed to work with us; since then they reduced our involvement, which we believe is another breach of good faith.

In order to try on——

Chairman **Stark**. Elaborate on that for me a little bit. You say they just wouldn't return your phone call?

Mr. **Lockwood**. No, last summer we sat down with the administration, talking to them about the difficulties of the issue, and offered to participate fully in those programs. What they have decided to do in the interim is to go outside the industry and go to a consultant.

Chairman **Stark**. Who were they using as a consultant?

Mr. **Lockwood**. I believe the Rand Corp.

Chairman **Stark**. Is there a lot of experience at Rand in medical problems?

Mr. **Lockwood**. I don't know that.

Chairman **Stark**. I know they know about weapons.

Mr. **Lockwood**. I am sure they have some experience, but our problem is that we wanted to participate in the solutions to the problem. We have not had that opportunity, and——

Chairman **Stark**. So we are really waiting on the Rand Corp., not on HCFA?

Mr. **Lockwood**. I think there are a series of things that you are waiting for.

In our hospital, case mixes continue to rise. The primary reason is many less severe illnesses are no longer treated on an inpatient bases. Some examples, since 1983, retinal procedures are down 40 percent; cataract procedures down 90 percent, uncomplicated cardic catheterization down 35 percent. All of those cause increase in the case mix.

We are proposing a freeze in the transition while major fine tuning of such issues as graduate medical education, both direct and indirect costs, disproportionate share, area wage adjustment and severity of illness are resolved. I believe in our organization we have solutions for measuring severity of illness. Such a solution would have reduced the length of this hearing, because discussions about indirect support for medical education and disproportionate share certainly would not have been as rigorous.

Since 1975, we have had a nursing acuity system in our hospital. I brought copies of it with me for the record. I thought this might be of help in dealing with the very difficult problems.

Chairman **Stark**. Thank you very much. Without objection, it will be made a part of the record.

Mr. **Lockwood**. We would be happy to work with the committee or its staff to try to deal with this issue.

Chairman **Stark**. I think we will probably hire Liberty Lobby or the Cato Institute to do our own research. That sounds like a good system to follow.

Mr. **Lockwood**. Our system shows an increase in the severity of the patients we treat of about 40 percent since 1975 and about 7 percent since 1983.

We are very concerned about continuation of the transition when a freeze in the payment rate is imminent. In our major hospital, St. Luke's Medical Center, continuing the transition while our payment rate is frozen will cost us about $2 million and will move us from being a viable institution to one very close to a negative bottom line.

This is especially serious to our church-related hospitals. Funds available for the treatment of charity patients are being reduced and Medicare is not the only cause. Changes by the States and private insurers are not only reducing payments, but increasing the number of charity patients. We are not asking Medicare to carry the load, but only to provide equity in its share so that we can carry out our mission as church-related hospitals.

We would be pleased to answer any questions.

[The prepared statement and attachment follow:]

STATEMENT OF BRIAN C. LOCKWOOD, PRESIDENT, COMBINED HEALTH RESOURCES, INC., PHOENIX, AZ, ON BEHALF OF THE AMERICAN PROTESTANT HEALTH ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is Brian C. Lockwood. I am a past chairman of the American Protestant Health Association ("APHA") and currently the president of Combined Health Resources of Phoenix, AZ, a multihospital system of not-for-profit hospitals. The APHA appreciates this opportunity to present its views on the critical issues related to the Medicare prospective payment system ("PPS"). We commend the subcommittee for holding hearings to examine this important issue in depth.

The APHA is comprised of 300 hospitals, agencies, and nursing homes across the country with 2,000 personal members in its division, the college of chaplains. The APHA has hospitals in 38 States, totaling 60,000 beds, and its hospitals are located in both rural communities and the inner cities. Although the APHA hospitals are church-related, they receive little or no direct financial support from the church. As an indivisible part of their religious commitment, the APHA hospitals serve large proportions of Medicare, Medicaid, and medically indigent patients. Thus, the PAHA hospitals are directly affected by the yet to be refined PPS of the Medicare Program.

This subcommittee has requested testimony concerning the PPS and various proposed changes, including: The impact of the scheduled transition toward national DRG rates in combination with the administration's proposed hospital payment freeze; the advisability of delaying this transition; the advisability of implementing a new area wage index; the implementation of a disproportionate share adjustment; proposals to reduce or eliminate the return on equity; and case complexity under PPS, particularly in light of the administration's proposal to reduce the direct and indirect medical education payments.

The APHA supports H.R. 1953, which delays for 1 year the scheduled PPS transition, if the administration's proposed freeze of the rates is implemented.

Such a delay is compelling for a number of reasons. The scheduled transition, coupled with the proposed hospital payment freeze, will result in many hospitals receiving substantially less in FY86 than they received in FY85. In addition, the Health Care Financing Administration ("HCFA") recently submitted its report on a new wage index which must be thoroughly analyzed to determine its accuracy and distributional effects. A delay also is required because of the administration's failure to implement a disproportionate share adjustment or to complete a severity study, even while it proposes to cut the direct and indirect education funding. Finally, the return on equity issue must be examined inlight of the overall capital payment issue to assure equitable treatment for all hospitals.

In comparison to other segments of the economy, the hospitals community is receiving the short end of the deal. For instance, the Senate's "freeze" related to the Department of Defense is a feeze after inflation, i.e., marketbasket. In comparison, the hospital rates would be frozen and from that base the administration proposes to subtract reductions in the indirect and direct graduate medical education payments, and further reduce payments by another uniform downward adjustment in the diagnosis related group ("DRG") weights. Moreover, the administration refuses to implement an adjustment for disproportionate share. It also has not completed critical studies on severity of illness and capital, and has ignored its commitment to the hospital community to examine with us the continuing rise in the case mix index.

This tremendous administrative power was left unchecked in the original PPS legislation which has since led a coalition of providers and consumer groups to propose legislation to establish an appeals process for providers and beneficiaries under PPS. Prophetically, Senator DeConcini, in a floor colloquy with Senator Durenberger, noted on March 18, 1983:

"Then the Secretary could cut the number of DRG's in half, or double the number, or do anything else he wanted at his total discretion. He could also refuse to change the relative weights of the DRG's even though it was absolutely proven that a given DRG was under or over weighted. This is particularly significant because, as I understand it, a relatively small number of DRG's account for the majority of all hospital discharges. The Secretary could make all these changes at his total discretion regardless of their impact on hospitals and patients. This is a very broad grant of discretion authority, and one that I believe may prove unwise."

The hospital community participated in a partnership with the Congress and the administration to create and implement the PPS, whereby medicare payments for inpatient costs of hospitals are determined prospectively on a per discharge basis. A fixed amount per case is paid based upon a DRG.

The PPS was to be phased in over 3 years from payments based on a blended rate of the individual hospital's historic costs and payments based on the new DRG rates. This transition period for PPS also includes a phasein of payments representing the nine regional payment levels to one national payment level, with separate payment levels for urban and rural areas. The blending formula began with the hospital specific component and the Federal component set at 75%/25% in the first year, moving to 50%/50% in the second year, 25%/75% in the third year and 100% national DRG pricing in the fourth year, i.e., for cost reporting periods beginning on or after October 1, 1986.

The annual increase in the PPS rates for hospitals originally was set at the marketbasket of hospital goods and services plus 1 percent. Under current law, the increase in the PPS rates for FY86 is limited to the marketbasket plus one-quarter of 1 percent. Thereafter, the annual increase is limited to marketbasket plus 1 percentage point.

Hospitals have had to absorb significant reductions in payments. Indeed, legislation enacted during the past 4 years has reduced medicare spending by approximately $24.7 billion from projected levels. Now, on top of those cuts, under the administration's proposed budget for FY86, the administration would bypass the Congress and by administrative fiat hold DRG rates at the FY85 level.

In contrast, the prospective payment assessment commission ("PROPAC"), an independent, statutorily mandated body to advise the Secretary on increases in PPS, recently recommended that hospital payments be allowed to rise by 1 percent to 3 percent, which would result in a $600 million saving in FY86. The adminsitration's rejection, in advance, of the recommendations of PROPAC, is an indication of a breach of faith with the hospital community which fully cooperated in 1983 with the Congress and the administration in creating the PPS.

Thus, following the already deep reductions, the administration's proposed budget slashes would further reduce payments and unfairly undermine hospitals, which already have contributed their fair share. Indeed, length of stay for Medicare patients has been reduced significantly, by 20 percent, since implementation of PPS, and admissions are also down in FY84 by over 4 percent from FY83. Hospitals also have responded to the Medicare reductions by implementing programs that have reduced Medicare cost increases by 13% while continuing to provide high quality care. Moreover, hospital costs rose last year at the lowest rate since 1963, at a 4.5% growth rate. Factors contributing to this low rate include a decrease of 1.5 million in admissions from 1983 and a drop in average length of stay from 7 to 6.7 days. At the same time, the decrease in hospital occupancy led to the closing of 11,000 beds in 1984 and 73,000 fewer hospital staff.

Thus, on top of these cuts affecting hospitals, the administration has indicated that it will again seek to reduce the DRG weights across the board (by up to 8 percent according to one report) when prices are set for FY86. The total rate reduction and the reduction of weights, coupled with the continuation of the PPS transition period in FY86, will result in many hospitals receiving far less in FY86 than they received in FY85. Implementation of the transition will further damage some hospitals' fiscal stability. For instance, the scheduled transition is projected to generate a $100 million loss to the State of Illinois. Illinois, however, is not alone. Several other States would experience a decrease in Medicare reimbursement in 1986 relative to 1985 caused solely by the continued transition to national rates: California (−2.3%); Massachusetts (−2.9%); Missouri (−3.3%); Nevada (−2.8%), to name a few.

Another factor necessitating delay is the belated area wage index report. An important part of the PPS was to provide for an adjustment of the labor related portion of the prospective payment rates to take into consideration differences in wages from area to area. The adjustment is implemented by means of an area wage index applied to hospitals within designated urban and rural areas.

HCFA has just recently completed a report on the wage index which must be studied to understand the distributional impact of the new index. There are disturbing indications that several hospitals will be seriously affected by the new wage index, such as hospitals in the Charlottesville, VA, area which will lose more than 20% under the new index. There also is some question whether the data collected by HCFA was adequate, and whether it was properly collected or interpreted. The APHA, therefore, supports any steps that would revise the wage index so as to eliminate to the extent possible the inaccuracies built into the present index. HCFA's report, however, must be closely studied and analyzed and pending that review, the PPS transition must be temporarily delayed to avoid further damage to hospitals. We recognize, moreover, that public policy considerations support making such revisions prospectively only.

Yet another compelling reason to delay the transition toward national DRG rates is the administration's failure to address, much less implement, the "disproportionate share hospital" provision of the act. Indeed, the Congress directed the Secretary to provide for such exceptions and adjustments as she deems necessary to take account of the special needs of "public and other hospitals that serve a significantly disproportionate number of patients who have low income" or who are medicare patients. The congressional intent of this clear directive reflects considerations of equity, i.e., treating hospitals fairly, as well as assuring the availability, accessibility, and quality of needed community health services. Thus, the Congress intended to make an adjustment to Medicare prices for hospitals serving a disproportionate number of low income or Medicare patients.

Congress repeatedly has reiterated its concern. For instance, in the Deficit Reduction Act of 1984, Public Law No. 98-369, the Congress further directed the Secretary to provide proposed criteria for identifying "disporportionate share hospitals" and to identify hospitals meeting these criteria. As stated in the conference report:

"The conferees wish to reaffirm their directive, contained in the 1983 legislation, that the Secretary provide for exceptions and adjustments for such hospitals if she determines them to be appropriate. The conferees also wish to express their concern about the adequacy of efforts that have been made to date to determine whether such exceptions or adjustments might be needed. In particular, the conferees note that no effort has been made to develop a definition of 'significantly disproportionate' for the purpose of identifying particular hospitals (or categories of hospitals) so that any special needs can be accurately and specifically assessed."

In February of this year, Chairman Rostenkowski, Chairman Stark and Mr. Rangel, sent a letter to HCFA urging compliance with the legislative directives.

The administration has staunchly refused to implement this provision of the act and has taken the position that Medicare costs are generally not affected by disproportionate numbers of low income or Medicare patients. The relationship between higher Medicare costs and disproportionate share, however, has been clearly demonstrated. For instance, a study by the American Hospital Association specifically found that "contrary to HCFA's assertion, "Hospitals having higher percentages of low income or medicare patients have higher Medicare costs per case. Importantly, the finding is statistically significant and therefore reflective of a systematic relationship." Other studies have reached the same conclusion. For example, the Congressional Budget Office ("CBO") found a specific correlation between disproportionate share and Medicare costs. It concluded that for each 10 percentage point increase in Medicaid inpatient days a hospital surplus (deficit) would decline (increase) by 2.5%. In addition, the District of Columbia Hospital Association also reported that based on a study of hospitals in five SMSA's, a facility with 20% Medicaid patient days could be expected to have a Medicare cost per case $710 higher than a facility with a minimal Medicaid case load. Even an internal HCFA analysis found a statistically significant impact of low-income patients on Medicare costs. This stubborn refusal by the administration to comply with unambiguous congressional directives justifies a delay in the transition, particularly since hospitals are apt to be deleteriously impacted.

The inadequacy of the PPS to adjust for case complexity coupled with the Administration's proposed budget cuts is a further reason compelling a short delay in the scheduled transition. The problem arises because DRGs do not recognize severity of illness. The Congress and this administration recognized this "blindness" by doubling the indirect graduate medical education factor. Although such doubling is not a precise methodology, it, nevertheless, is and has been recognized as a proxy for severity. Indeed, 1982, in a report to Congress, the Department of Health and Human Services stated:

"The *indirect* costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs . . . it is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. . . . the Department believes that recognition of these *indirect* costs should be accomplished through a lump-sum payment, separate and distinct from the base rate."

The Senate report also recognized the deficiencies the doubling adjustment would help alleviate:

"This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs in only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals." (S. Rep. No. 98-23.)

The administration's proposed budget cuts would greatly exacerbate the inequities caused by the inability of the DRG's to measure severity. Indeed, the proposed budget would cut by half the indirect teaching adjustment which is a doubling of the pre-PPS adjustment factor, currently 11.59%. While APHA does not object to some fine-tuning of the indirect adjustment, there is no justification to support cutting it in half, especially since it was implemented in 1983 because the DRG's, as noted above, do not recognize a severity of illness factor—a conspicuous omission which still has not been corrected by the administration. The reduction of the indirect medical education factor will greatly strain the financial stability of hospitals treating patients with severe illness, such as teaching hospitals.

The teaching hospitals are in a particularly precarious position because by their nature they have a higher number of cases of severe patients and concomitant higher costs. Reducing the indirect graduate medical education factor by half thus would have a dramatic negative impact on such hospitals. At the same time the budget reductions would not solve the original problem because of the absence of a severity index. (By definition, the indirect teaching adjustment relates only to teaching hospitals; however, an appropriate severity measurement would relate to all PPS hospitals.)

The lack of a severity adjustment in combination with the proposed budget cuts to indirect education would further reduce payments to hospitals. A delay in the transition is needed to enable the administration, the Congress and the hospital community to develop a severity index and thereby assure a more equitable PPS and therefore a viable hospital community that is able to continue to provide high quality health care.

The administration also proposes to "freeze" indefinitely the direct medical education pass-through at FY84 levels, which includes programs such as the costs of graduate medical education programs for interns and residents salaries and classroom costs. This "freeze," coupled with the transition, will have a direct impact, not only on the training for new physicians, but also on the quality of care being provided. Thus, the role of graduate medical education must be studies before any further changes are implemented. (One thoughtful suggestion is to limit the direct, GME to the clinical time necessary for primary board certification.) A brief delay in the scheduled transition would afford the hospital community and, hopefully, the administration and the Congress time to better understand the impact of medical education on the health care system.

What is unstated in the administration's proposed cuts is that hospitals must make do with less at a time when their financial viability is further being threatened by burgeoning uncompensated or charity care pressures. Indeed, access to health care services for indigent patients who are uninsured or underinsured poses tremendous challenges for our entire society.

The growing number of uninsured or underinsured patients is beginning to place great strain on certain hospitals in light of the increasing pressures embodied in the PPS and Medicaid reductions as well as in State, local, and private health insurance cutbacks.

The problem is highlighted by the Department of Health and Human Services national medical care expenditure's survey which concludes that more than 25 million persons are uninsured at any point in time. Up to 34 million persons may be uninsured for some period of time during the year while approximately 18 million persons (8% of the population) are without insurance for the entire year and 16 million (7% of the population) are uninsured for some portion of the year. These persons include individuals who either are not covered by Medicaid or other similar programs, or who do not have private insurance coverage due to unemployment, job transfer, or lack of insurance provided by an employer. Many of them are indigent and because of their financial condition are unable to pay for health care services, giving rise to uncompensated care being provided by hospitals. Thus, the American Hospital Association estimates that hospitals provided approximately $6.2 billion of such care in 1982—the most recent year for which data are available. Of this amount, $1.7 billion represented charity care. The aggregate amount is a dramatic increase from the $3.7 billion spent in 1979, and this trend continues.

The irony of the situation is that if HCFA would develop an appropriate severity index, there would be no need for the indirect education proxy for severity or, for that matter, the adjustment for disproportionate share hospitals. In the final analysis, the PPS as whittled away in the past 3 years not only fails to recognize adequately the severity, intensity, and complexity of patient illnesses, it also increases the hospitals' uncompensated cr charity care burden. The transition must now be frozen, otherwise the massive budget cuts coupled with the scheduled transition will result in reduction in hospital staffing and an erosion of the high quality of health care which is the hallmark of our Nation.

A related reason justifying a delay is the need for an equitable resolution of the return on equity issue. The APHA consistently had supported the concept that all hospitals are entitled to return on equity. Accomplishing that goal could be achieved through one of the several capital payment plans now under consideration by HHS, such as the total revenue approach, which would involve rebasing all the DRG's to include both operating and capital data. Thus, this would remove the distinction between hospitals by class of ownership. One option would be to freeze the PPS transition, and then begin, say, a 5-year phase in of the total revenue plan. All of these plans, however, including the Medicare fair payment for capital plan, should be carefully examined, in separate hearings after the HHS capital report is delivered to the Congress, to insure that all categories of hospitals are treated equitably.

In conclusion, hospitals have already absorbed significant reductions in the past and many simply will not be able to survive another blow to their financial stability. The drastic cuts for hospitals must also be viewed in conjunction with the administration's failure to implement adjustments and studies which would make the PPS far more equitable, such as: A disproportionate share adjustment; the joint HHS-industry study of the case mix index, promised in August 1984, to determine whether hospitals are treating sicker patients under PPS, and the development of a severity index to determine whether the resources used to treat a Medicare patient within a particular DRG necessitate adjustments. Eash of these factors alone would suggest a delay of the scheduled transition; in the aggregate they compel a delay, especially in conjunction with the proposed rate freeze.

The APHA wishes to stress that it will continue to work with the Congress and the administration to devise a fair health care system which will promote the goals of PPS without jeopardizing the availability and quality of necessary and appropriate health services to Medicare and Medicaid patients. Again, APHA appreciates this opportunity to testify and I will be pleased to answer any questions.

St. Luke's Hospital Medical Center

A PATIENT CLASSIFICATION SYSTEM
for
STAFFING AND CHARGING FOR NURSING SERVICES

By

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PREFACE

The objective of hospital management is to provide the community with the health services it needs at an acceptable quality level, and, at the least possible cost. The belief that staffing (number and type of nursing personnel) has a definite relationship to cost, staff efficiency, and the delivery of therapeutically effective health care resulted in St. Luke's Hospital developing a unique system. This system encompasses the classification of patients according to illness (acuity), the scheduling of the nursing staff, and the billing of patients for care rendered.

The purpose of this manual is to share the process and products of this system with other health care providers with the intent that other patient populations may have the benefit of our experiences.

The manner in which the material is presented is simplistic and graphic. The human processes required to develop this system are not included, as they were numerous. The project has been frustrating, discouraging and a source of worry; but, more important, it has been challenging, rewarding and worthwhile.

The many persons contributing to this development can never be named, for the list is endless; but a special thanks is due those listed on the special Recognition Page, those who contributed by reading, suggesting, supporting and nudging this endeavor into realty -- Brian Lockwood, Robert Theilmann, Doctor Eva Erickson, Nancy Melvin, Anne Fangman and Barbara Scott -- and most importantly, the nursing staff, who, in its daily professional activities, live, practice and continually develop this acuity system.

HISTORY

St. Luke's Hospital began developing a hospital-wide, cost-based financial system in 1971. The system was designed to operate in a functional manner within the hospital's fiscal philosophy. This required that:

- The price of each individual service should be based upon the cost of providing that service
- Pricing departmentally or on a program basis should be adequate to sustain financial accountability
- Sufficient funds be generated to provide for current operating needs related to patient care, preservation and replacement of plant equipment, improvement and expansion of equipment and facilities, and amortization of indebtedness and working capital needs

Nursing Administration expressed the belief that patients' needs for nursing care varied with the level of illness; that different types and numbers of personnel were required to provide care for each level; and therefore, the cost of nursing care varied with each level of illness. Thus a composite of patients' illnesses (rather than census) determines the total number and type of staffing required and the cost of providing nursing care on a nursing unit.

It was our belief that a cost-based system could be designed to incorporate these factors and to generate variable charges for nursing service. Since nursing service was the largest single staffing component of the hospital and often a target for staffing reductions, it was decided to develop a system to identify and support staffing requirements and establish patient charges.

A study began in the fall of 1971. By July, 1974, a patient acuity system comprised of four primary components was developed. These sub-systems include:

- patient classification
- staff allocation
- patient charges
- validation and audit

The originial system has seen several revisions, which have addressed significant deficiencies. The focus of this manual is on the current system, although periodic reference to the Year I and to the Year II systems occurs.

PATIENT CLASSIFICATION SYSTEM

The patient classification system is a process by which each patient's illness and nursing care requirements are rated according to a series of definitions. A summary of the points assigned these definitions result in their categorization into an established "acuity"level. By our definition, acuity is the level/degree of patient illness.

Due to the hospital patient population, two different patient classification systems evolved: one covering Medical-Surgical patients and the other covering Behavioral Health Services patients.

The process of evolution was identical, but not simultaneous. The Medical-Surgical system was developed first. The Behavioral Health Services system, which followed, benefited from the experiences and problems of the initial system.

Development and testing of each system involved nurses working on a task force. This group represented each unit, shift, and R.N. position, and was assisted by our outside consultant. The task force approach consisted of multiple, informal work sessions away from the hospital. Task force activities involved a review of literature, brainstorming, definition of terminology, establishing categories, assigning points, clarifying and building in quality control components, and creating required rating tools. Procedures were written and the total system designed and tested using medical records, so that a pilot study could be accomplished. The pilot study resulted in further evaluation, redesign and retesting prior to house-wide initiation.

Medical-Surgical Overview

The Medical-Surgical classification system is composed of seven categories for patient rating purposes. These include:

- Diet
- Bath
- Mobility
- Medications
- Behavior
  (patient response to environment)
- State
  (patient internal and external environment)
- Treatment

Each category has a multiple number of terms, with each term having specific definitions. The number of terms in each of the seven categories is variable, because the intent was to develop each category to its fullest. Each term is defined as specifically and objectively as possible to limit subjective interpretation. Beliefs and values were purposefully included: for example, patient/family teaching is incorporated into each section, because we believe that one of the primary roles of the professional nurse is to teach the patient and/or family.

The terms were graduated, sequenced and point values assigned according to the:

- Type of activity performed with/for a patient/family (as determined by need or request)
- Frequency and time involved with each activity (as determined by experience and activity study results)
- Type of personnel required to perform the activity at a quality level (as determined by experience and nursing service philosophy)

Based on the nursing care provided, the patient is rated in each and every one of these seven categories. Multiple selections in each category are encouraged to provide a clearer patient profile. However only the highest point value in each category is added into the total "raw score." The raw score is the sum total of the number of points derived from the seven categories. Currently the maximum possible point total is 103, while the minimum possible score is 26. (Table 1)

Category	Minimum Points	Maximum Points
Diet	2	8
Bath	1	5
Mobility	2	10
Medications	5	25
Behavior	5	15
State	4	20
Treatments	7	20
Total	26	103

Table 1 - Minimum and Maximum Point Values

Raw scores were plotted for approximately 150 patient records that the task force rated. These plots then developed a group of histograms and the five acuity ranges established. (Table 2)

Point Range	Acuity Classification Level
26 - 37	1
38 - 55	2
56 - 70	3
71 - 83	4
84 - 103	5

Table 2 - Point Range by Acuity Level

Nursing care is, therefore, provided according to the patient/family needs and requirements. The point range established by the patient's condition determines the acuity level of the patient. Thus the acuity level represents nursing care provided according to patient illness and nursing care needs.

Nursing Care Record

Originally the patient classification system was incorporated into a three-page kardex. Acuity charting occurred on a specially designed "Treatment Record" and Nurses' Notes. Due to inconsistent validation audits (an audit to compare the patient's bill with the nursing documentation in the medical record), the patient classification system was incorporated into a chart form -- Nursing Care Record -- and deleted from the kardex.

The Nursing Care Record, generally known as Nurses' Notes in health care is a form which facilitates nursing care documentation, establishment of patient acuity, and generation of the charge for nursing care in a single process. This form is the legal document in the patient medical record. (Exhibit A) Also it provides staffing information for the following day. It is a two-part form that consists of a data processing charge ticket and the documentation component. Each shift rates the patient in each of seven categories. At the end of each shift, the highest point value in each category is totaled in each section (Acuity A, B and C) and written in the appropriate shift column on the upper left hand corner of the data processing ticket. The subtotals A, B and C are added. The total points establish the acuity level.

If terms with red dots in the Nursing Care Record have been used, then written supportive documentation is required in the "Notes" section, which is on the reverse side of the form. The "Notes" section is also used to record physiological/psychological baselines and variances, new symptoms, unusual occurrences, family concerns, teaching content and results, prn medications, etc. Charting is based on exceptions or changes, rather than repetitive, routine events. In lower acuity levels the "Notes" section may be void of entries.

Each person with assigned responsibility for the patient signs in the "Signature" section. All nursing personnel (registered nurses, licensed practical nurses, nursing assistants) participate in the completion of the form. The nursing assistant and the L.P.N. generally complete Section A; the L.P.N. and the R.N. complete Sections B and C and the "Notes" section. Charting on the Nursing Care Record occurs at all times throughout the twenty-four hour day. Each form represents one twenty-four hour period.

There are several unique situations which supersede and revise the established acuity level: patient on pass, and private duty nurses. If a patient is on pass, an acuity "0" is assigned for that shift, assuming non contact with the nursing staff has occurred. If one or more contacts with the nursing staff have occurred, then an acuity "1" is assigned to represent the therapeutic intervention provided for the patient/family. If the patient has a private duty assignment, then the acuity allocation is as follows:

- If a sitter is used, no change is made in the acuity, since sitters do not provide nursing care
- If the private duty individual is an L.P.N., the acuity can be reduced one level. The R.N. team leader retains full responsibility for the patient
- If the private duty individual is a registered nurse, the acuity can be lowered to Acuity 1. This acuity is always retained since the R.N. team leader still maintains responsibility for the patient

The Nursing Care Record format has given the Nursing Department numerous benefits over the prior system:

- Terms requiring support documentation are readily identified
- Support documentation occurs on the same form, facilitating continuity and generating a twenty-four hour care picture
- Repetitive, meaningless charting (e.g., "Good Day") is avoided
- Charting is done at a time functional for each team member

- Charting and acuity assessment are synonomous -- eliminating a double process
- Establishing the acuity is no longer a low priority task, as it occurs in the charting process
- Charting establishes the staffing needs for the following day
- Clarity of acuity assists other departments with establishing patient illness and planning their work load

Behavioral Health Services Overview

The Behavioral Health Services classification system has three broad categories: Milieu, Counseling and Somatic. The belief that the nurse strongly influences both the physical and interpersonal environment of the patient is incorporated throughout this system.

The nurse's responsibility for both the therapeutic program, the living situation, and the patient's response as he/she experiences life on the nursing unit are the focus of Milieu. Milieu has two subdivisions: activities and behavior. Activities refer to staff functions and activity, while Behavior refers to patient functions and activity.

Activities were sequenced and point values assigned according to the:

- Frequency and time involved with each activity (as determined by experience and activity studies)
- Interruptive quality of the activity
- Type of personnel required to perform the activity at a quality level (i.e., having the knowledge and competence to perform the activity)

Behavior reflects a gamut of patient behaviors from those which enhance the use of the program to those which curtail the patient's personal use and/or affect other patients' use of the program. While this section primarily reflects patient behavior, the family's behavior is included. In that the patient and family are viewed as a unit, successful treatment of the patient may depend on effective intervention with the family. Consequently the family behavior, which requires nursing care and time, is acknowledged in the acuity.

The Counseling Section denotes a mix of staff activities and patient/family states or behaviors. The items included are only those which adversely affect the counseling process.

Somatic refers to chemotherapy, the major adjunctive therapy utilized. Both staff activities and patient behaviors are incorporated into the terms.

The dynamics of patient behavior were not incorporated in all aspects of the classification system. Only the behavior or outcome with which the nurse must deal is reflected. Although the definition of each term is as specific as possible, the definitions are not totally exclusive and can be expanded to like situations.

The minimum point value is 22 points, while the maximum point value is 100 points (Table 3).

Category	Minimum Points	Maximum Points
Milieu		
Activities	5	30
Behavior	5	30
Counseling	7	25
Somatic	5	15
Total	22	100

Table 3 - Minimum and Maximum Point Values

The patient is rated in each category and multiple selections are encouraged. The highest point value in each category is added into the total "raw score." The raw score falls into one of five point ranges or acuity levels. (Table 4)

Point Range	Acuity Classification
22 - 37	21
38 - 50	22
51 - 63	23
64 - 79	24
80 - 100	25

Table 4 - Point Range By Acuity Level

The first digit defines, for the computer, the specific nursing care charges, which vary between and within medical-surgical and behavioral health services, while the second digit is the actual acuity level.

Like the Medical-Surgical System, the Behavioral Health Service Classification System (Year I) was incorporated into a two-page kardex. The acuity charting was done on a Treatment Record with further documentation in the Continuous Progress Notes. In Behavioral Health Services all health care team members, including physicians and therapists, chart together on Continuous Progress Notes. Validation/audit results were also inconsistent in this service, so again a Nursing Care Record evolved.

Nursing Care Record

The structure of this form (Exhibit B) and the process for using it are almost identical to the Medical-Surgical Nursing Care Record. The only variances from the Medical-Surgical record are the content, the omission of subtotals due to fewer categories, the absence of a "Notes" section and an additional signature line. Charting in conjunction with the health team is an essential component of the total therapeutic process and was deemed too important to forfeit for a separate nurse's note section. Due to patient mobility, more than two members of the nursing staff are often involved in patient interactions and contribute to the documentation.

STAFFING SYSTEM

Activity Studies

To determine nursing activities and their relationship to patient acuities, several activity studies were conducted. Prior to starting the work, various methods were considered: formal time study, work sampling, continuous observation and self reporting. Due to study mechanics, staff acceptance, cost and desired outcomes, a self-reporting format was selected for the activity study.

A pocket-size form was designed (Exhibit C) on which the patient room and bed number, the activity, and the time the activity started were recorded in sequence by each team member. The time required for each activity was determined by subtracting each start time from the following start time. Using the patient's room and bed number, the patient's name and acuity were obtained from a master list. In Behavioral Health Services the patient's first name was used due to patient mobility.

Inherent invalidities and uncontrolled variables associated with this methodology were recognized. Only activities and time were measured -- activity complexity, effectiveness of outcome, appropriateness of activity, omissions, interruptions, etc. were not measured.

A series of categories by which the data would be classified were established. These categories have been refined and expanded with each successive study. The categories fell into three general divisions:

- Direct Care: Any type of care provided to that patient or family at the bedside or directly with the patient or family
- Indirect Care: Activities provided for patients that could not be identified specifically for any one patient, such as preparation of medications for the entire unit
- Miscellaneous Activities: Activities that occur regardless of patient census or illness, such as report, charting physician rounds, etc.

The data from each activity study was summarized by computer by individual categories and divisions, and according to shift, type of nursing personnel and patient acuity.

A three-day pilot study on one unit was completed to test the self-recording form and the classification categories. The pilot study was followed by a seven-day study on every unit (House Study One.) Head nurses, registered nurses, licensed practical nurses and nursing assistants were included; unit secretaries, students, orientees, outside registery personnel and service coordinators were excluded. As anticipated, House Study One found the then existent patient classification system, four levels of care that had minimal definition, to be inadequate. House Study One results were used in assigning points to the activities in each category of the acuity classification system.

House Study Two, a three-day activity study, was completed in order to validate the new acuity classification system and gain a data base for developing the staffing system. Later Behavioral Health Services completed an additional three-day study in order to re-evaluate the staffing computations. One especially noticeable item in the Behavioral Health Services area was that measurable tasks involving a single patient at one time occur with low frequency, while group activities and non-visible therapeutic interactions and interventions occur regularly within a mobile patient population.

Activity studies utilizing a self-recording format interfere with the nursing staff's natural work flow. Although a self-recording method provides a large data base and provides a good foundation, its interference with work flow diminishes the quality of data.

A continuous observation study in the Acute Care Unit will be designed and completed at a later date. In the Acute Care Unit (surgical intensive care and coronary care) the self-recording method was not functionally possible.

Staffing Calculations

The activity study data was summarized into minutes of care according to patient acuity class by type of personnel. The data was plotted and a curve-fitting computer program used to determine the line of best fit. This curve is shown in Exhibit D .

A staffing matrix was then determined showing the number of full-time equivalents (one person at forty hours per week) required to care for a given number of patients in a specific acuity level for a twenty-four hour time period. (Exhibit E) Four matrixes were then developed:

- Medical-Surgical
  - Registered Nurse/Licensed Practical Nurse
  - Nursing Assistant
- Behavioral Health Services
  - Registered Nurse/Licensed Practical Nurse
  - Technician

L.P.N.'s were categorized with R.N.'s due to the small population of L.P.N.'s. This should not imply that L.P.N.'s replace or substitute for registered nurses.

During Year I and Year II the head nurse data was included in the matrix calculations. In Year III the head nurse data was extracted due to the head nurse role changing significantly.

Time values for each classification of patients were taken from the curve and a calculation made to obtain a relative value relationship. Relative value is a cost allocation methodology that places many kinds of items into a systematic relationship. Relative value units reflect the relative relationships as they relate to each other in the group. For example, one Acuity 5 patient is equal to three Acuity 1 patients. An Acuity 5 patient requires three times the nursing care of an Acuity 1 patient. The relative value relationship was used in the development of the staffing system and is one of the primary methods for developing nursing care charges.

Staff Allocation

The staffing system is initiated in the Nursing Care Record where the acuity of each patient is determined on each shift. By 2330 hours (11:30 p.m.) charting and the data processing slips are removed from all Nursing Care Records and the acuities tabulated and recorded on a Matrix Batch Control Slip. All the data processing slips and the Matrix Batch Control Slips are sent to the staffing office. In the staffing office, the information is recorded and staffing for the next twenty-four hours computed, using the staffing matrix. In general staffing is distributed 40 per cent to days and evenings and 20 per cent to nights. The Matrix Batch Control Slips are then sent to Data Processing for keypunching the nursing care charges for each patient's hospital day.

The team leader also records each acuity on a Condition Report. The Condition Report is a computer-generated list of each patient by name, age, hospital account number and previous acuity. The list is printed at approximately 0200 hours (2:00 a.m.) each morning and reflects the prior evening acuity. At the end of each shift, the actual acuities are recorded on this form. The Condition Report is used by team leaders as a master list to guide staff assignments, record discharges and list admissions.

If, at 1100 hours (11:00 a.m.) there has been a census change of four or more patients, the head nurse or her designee requests an update and recalculation of staffing requirements for the 3 - 11 shift and the 11 - 7 shift. Known admissions are counted as an Acuity II patient for Medical-Surgical and a III for Behavioral Health Services. This step prevents the 3 - 11 shift from being penalized due to a significant census change.

With this process, staffing is based on actual acuities, not best "guesstimates" of acuities. In addition charting has been completed and reflects the entire shift.

In summary this system enables staffing to be based on nursing care requirements, rather than patient numbers. In practice it is more equitable and functional for both the patients and the staff.

ACUTE CARE UNIT

The Acute Care Unit has a two-level acuity system developed from experience and observation rather than from a methodical study of the unit. The system is based on the amount of nursing care provided:

- Acuity 6 (Provides for one nurse for each two - three patients)
- Acuity 7 (Provides for one - two nurses for one patient)

Acuity 7 patients are those patients who had open-heart surgery within the last twenty-four hours, requiring intra-aortic balloon pumping, or in a severe, unstable physiological and/or psychological state, such as severe trauma, acute phases of chronic obstructive pulmonary disease, severe congestive heart failure, Swan-Ganz catheter, cardiac and/or respiratory instability indicating impending and/or following code arrest. The unit will be studied by an observer/recorder approach this year.

A specific kardex or charting system has not been designed due to the utilization of a clinical computer system through which the charting is completed. It is anticipated that computer charting will be modified with the design of a Nursing Care Flow Sheet. This unit is staffed on a shift basis, since patient turnover is fairly rapid.

PATIENT CHARGE SYSTEM

One of the original intents for developing this system was to establish cost-related patient charges. At St. Luke's the patient is charged separately for room, dietary and nursing care. The nursing care charge is a variable charge based on patient acuity and staffing requirements.

The minutes of care per patient day taken from the graph (Exhibit D) were converted into relative value units in the acuity computation. The concept of relative values has been in use in health care in areas such as clinical laboratories where tests vary as far as equipment required, personnel, or time to perform the test.

The calculation required to translate the relative values shown in the scheduling matrix into corresponding charge rates is as follows:

- Multiply actual patients' days (or budgeted patient days) by the corresponding relative value to obtain weighted patient days
- Summarize these data into total weighted patient days
- Multiply the actual total patient days by the average rate per day for nursing care. (During Year I this average rate was $39.00). This calculation can also be replaced by budgeted nursing expense
- Divide this total (C above) by the weighted patient days (B above) to obtain the rate for a base value of 1.00 units of nursing care
- Multiply the base value times each individual acuity class relative value. Obtain the charge rate for that class of nursing care
- Round the data to the even dollar

The patient's bill shows the acuity level and the rate for that level. The rates are summarized by level: e.g., five days' Acuity I at $40.00 each = $200. This itemization enables the patient to identify the amount of nursing care received per day.

On a random basis the medical record is audited against the patient's bill. The auditor reviews the record and determines whether or not the acuity level can be validated by the numbers and support documentation. For internal audit purposes, the support documentation is considered most important, as this portion of the charting is essential to maintaining our charting standards.

In summary nursing care is provided and documented on the Nursing Care Record, staffing is computed and implemented, and nursing care charges are generated in a single process.

ACUITY VALIDATION AUDIT

The acuity validation audit evaluates the documentation of the acuity charting as related to nursing care charges. A form was designed to assist the auditor to systematically audit a chart or series of charts. The form is used by the auditor to document specific findings in an organized fashion. The number of current patient records audited each month is determined by using a statistical sampling method that takes into account hospital and unit census. Audits are performed all during the month and reports issued when a unit is completed. Detail reports are issued to the responsible head nurse and also nursing administration. Summary reports are issued to hospital administration.

The selected patient day is audited by reviewing each shift's documentation. The process involves the use of the total medical record, including physician orders. In this way, particular shift problems, as well as personnel or specific interpretation problems, can be identified. A measure of the total medical record quality is also obtained as a by-product of the audit.

The audit procedure is the same for Medical-Surgical and Behavioral Health Services Units. Each audit takes from ten to fifteen minutes to perform and varies with the complexity of the medical record. The audit is viewed as a teaching process and the results discussed with specific unit personnel.

STATISTICS

Statistical monitoring is a basic requirement to assure that any system is operating correctly. Since St. Luke's shared a computer with sixteen hospitals in the community during those first two years, the monitoring controls were designed to be performed manually. This will be changed as soon as the hospital's in-house computer becomes operational.

Acuity statistics are currently being maintained by the staffing office. Two monitoring forms are prepared: Daily/Monthly Statistics by Units and Acuity-Weighted Graph.

The Daily/Monthly Statistics by Unit form (Exhibit F) contains the following information that is posted daily:

- Daily record of patient distribution by acuity for the specific nursing unit. The source of this information is the Matrix Batch Control form submitted by the unit at 2330 hours (11:30 p.m.)
- Total personnel hours worked each day. Head nurses, unit secretaries, students and orientees are excluded from this count. The source for this information is a staffing worksheet of all persons on duty during the twenty-four hour period
- Direct nursing care hours per unit. Direct care hours are tabulated because direct care hours vary directly with acuity and are used for a correlative review of acuity and staffing. Direct nursing care hours do not take into consideration patient transfers, admissions, discharges or acuity levels. Since staffing should increase or decrease with acuity levels, then direct nursing care hours should vary in the same direction. This is computed by dividing the total number of hours worked for twenty-four hours by the midnight census.
- The personnel not counted for staffing purposes, such as head nurses and orientees, are recorded in the "no-count column. ("No count" only refers to staffing). Unit

secretaries, service coordinators and clinical specialists are not counted or recorded in this statistical summary. The source of this information is the Staffing Worksheet.

- Number of orientees per twenty-four hour period. The Staffing Worksheet reflects the number of persons in orientation. Orientees are not counted, even though they are salaried during the orientation period.
- Record of staffing variance between staffing required according to matrix and actual staffing provided. This is determined by comparing the Matrix Calculation Sheet and Staffing Worksheet.
- Weighted Acuities. Every seven days, the acuity distribution is totaled and weighted by level according to the following formula:

Acuity	Patients		Weighted Value
1	71	=	71
2	80	=	160
3	30	=	90
4	14	=	56
5	13	=	62
TOTAL	208	=	442

$$\frac{\text{442 Weighted Value}}{\text{208 Actual Patients}} = \text{Weighted average acuity for 7 days or 2.13}$$

The weighted average acuity is recorded on the Daily/Monthly Statistics form and graphed (Exhibit F .) The graph, which visually describes the distribution trend of acuities, has defined "safety zones." These "safety zones" visually depict the variance in acuities that can occur as a normal distribution.

Nursing Administration monitors the graph and initiates an investigation when acuities fall outside the safety zone. Financial Services monitors acuity, using dollars of revenue as the comparison data each month. The importance of a statistical monitoring system cannot be over emphasized -- as variation in acuities has significant financial impact.

OPERATING ROOM ACUITY

The concept of graduated levels of care and charges are not unique to nursing units. The operating room has developed a four-level patient classification system that is study based and results in variable patient charges.

Over a twelve-month period, procedures representing all types of surgery were studied in detail. Of the cases studied, 599 procedures were included in the final data base. Although a work form was developed, the operating room personnel abandoned its use for a more functional form -- blank paper -- on which every non-chargeable item utilized throughout each procedure was recorded.

The final cost analysis process included facilities, labor, non-chargeable supplies, non-chargeable equipment and linen packs. In terms of facilities, a basic operating room with standard built-ins, equipment and lighting was established. Depreciation was calculated and included, with the open heart room and laminar flow room having higher depreciation due to specialized "standard" equipment.

Actual staff labor with a utilization factor of 50 per cent was calculated. The average clean-up and set-up times were established by a committee of operating room personnel. The operating room supervisor and the clerical staff were not included but incorporated into department overhead costs.

Non-chargeable supplies, such as prepping solutions, standard dressings and sutures were determined from the study data. Non-chargeable equipment or instrumentation was also calculated on standard setups. Linen costs were based on a predominance of linen, not disposable drapes. Individual charge items, such as monitoring equipment, electrocautery units, irrigating solutions, implants, etc. were not included in the study.

Portal-to-portal time was used for computing staff and room time. The time period increments were established at a one-hour minimum base with fifteen-minute increments.

Initially, five classes were anticipated. The 599 cases were plotted and a curve of best fit calculated. The outcome was the verification of the data base and the establishment of four classes of acuity, after the conclusion that the moderate and major classifications did not present a significant variation in cost. This data was then converted into relative value units, which were compared with the distribution of procedures. The outcome of charges established were:

Class	Hours Service Distribution %	Relative Value	Original Charge Per 1 Hour
1	5	1.00	$ 50.00
2	58	1.27	65.00
3	17	1.81	
4	20	2.63	134.00

The new acuity rates equalled a $0.59 increase per hour (0.7%) over prior fiscal year rates. A general overview of the procedures by acuity classification is as follows:

Acuity 1	Those procedures involving minimum setup/draping and only one surgery nurse, such as non-invasive and cysto room procedures.
Acuity 2	Those procedures with routine draping, instrumentation and suture material. A standard surgical team (one scrub and one circulator) is required. Examples are abdominal, opthalmic, plastic and orthopedic procedures.
Acuity 3	Those procedures that utilize laminar flow require more than the standard surgical team (three persons), utilize more than one setup during the same operating room visit and/or require special instrumentation and suture, such as vascular and thoracic procedures.

Acuity 4	Those procedures that utilize the maximum amount of sophisticated equipment/instrumentation and experienced personnel, such as total joint replacements, extra corporeal bypass and craniotomies.

Individual or direct charges are marked by the circulating nurse on individualized operating room charge tickets. The charge tickets are completed (time computed by acuity level) each day and forwarded to Data Processing for keypunching.

The acuity system in the operating room has been instrumental in justifying staffing requirements. Statistical data reflects the acuity levels and provides a more descriptive record of actual workload.

SUMMARY

The intent of this manual was to share the development process and current products of a sophisticated system that includes patient classification or acuity, nurse staffing and individual charges for nursing care. We have committed thousands of man hours and dollars to its development. By much trial and error, we have accomplished a system that meets the requirements of our hospital.

Although not totally perfect, we believe, with pride, that this is the most comprehensive, yet functional, system in operation in this country. We totally believe in, and are committed to, the concept of acuity and urge you to consider the applicability of this concept to your system.

As an expression of community service, we would be glad to have you visit us, so that we might personally answer your questions and provide more details. Thank you for sharing in this experience with St. Luke's Hospital Medical Center.

Exhibit A

STANDARD FORMS CO. – Phoenix · Las Vegas · California

ST. LUKE'S HOSPITAL MEDICAL CENTER
Phoenix, Arizona

● DISCH TIME	CODE	ABBREVIATIONS N = NITE B = BREAKFAST D = DAY L = LUNCH E = EVENING D = DINNER	N	D	E
POINTS	LEVEL	SUB-TOTAL ACUITY 'A'			
26- 37	1	SUB-TOTAL ACUITY 'B'			
38- 55	2	SUB-TOTAL ACUITY 'C'			
56- 70	3	TOTAL POINTS			
71- 83	4	ACUITY LEVEL			
84-103	5				
DATE		● ☐ ON PASS ☐ PRIV. DUTY			

DATA PROCESSING COPY

DIET		Refused None Partial Total	B	L	D
NOURISHMENT					
ACUITY 'A'			N	D	E
DIET	DIET CHECK		2	2	2
	NPO		2	2	2
	SELF		2	2	2
	ASSIST c̄ TRAY		5	5	5
	SIPS/CHIPS		5	5	5
	INTAKE/OUTPUT (FORCE/LIMIT)		5	5	5
	ASSIST FEED		8	8	8
	TOTAL FEED		8	8	8
	GAVAGE FEED		8	8	8
	● TEACHING FEED		8	8	8
	● COMPLEX TOTAL FEED		8	8	8
BATHING	ENVIRONMENTAL CHECK		1	1	1
	TUB s̄ HELP		1	1	1
	BATH s̄ HELP		1	1	1
	SHOWER s̄ HELP		1	1	1
	SELF-HELP (BEDSIDE)		2	2	2
	H S CARE		2	2	2
	TUB c̄ OCCASIONAL CHECK		2	2	2
	SHOWER c̄ OCCASIONAL CHECK		2	2	2
	COMPLEX H S CARE		4	4	4
	PARTIAL BATH		4	4	4
	COMPLETE BATH		4	4	4
	● COMPLEX BATH		5	5	5
	● TEACHING BATH		5	5	5
	● MULTIPLE BATHS		5	5	5
MOBILITY	Q__________ H CHECK		2	2	2
	UP AD LIB		2	2	2
	CHAIR		2	2	2
	BRP		2	2	2
	● AMBULATE c̄ HELP		5	5	5
	● BRP c̄ HELP		5	5	5
	● CHAIR c̄ HELP		5	5	5
	BEDREST c̄ BRP/COMMODE		5	5	5
	BEDREST		5	5	5
	COMPLETE BEDREST		8	8	8
	● COMPLEX ACTIVITY		8	8	8
	● TEACHING ACTIVITY		8	8	8
	TURN Q________ H		8	8	8
	TOTAL LIFT Q_______ H		10	10	10
	STRYKER/CIRCLE BED TURN Q_____ H		10	10	10
	● SOFT/LEATHER RESTRAINTS		10	10	10
SUB-TOTAL ACUITY 'A'					

ACUITY 'B'		N	D	E
MEDICATIONS	MEDICATION KARDEX CHECK	5	5	5
	ROUTINE s̄ IV's	8	8	8
	ROUTINE c̄ IV's	15	15	15
	MULTIPLE MEDS	15	15	15
	HEPARIN LOCK	15	15	15
	● TEACHING MEDICATIONS	15	15	15
	● ASSESSMENT MEDS	15	15	15
	ROUTINE c̄ MULTIPLE PIGGYBACKS	25	25	25
	● BLOOD TRANSFUSIONS/OBSERVATION	25	25	25
	● ADMINISTRATIVE/FREQUENT INTERVENTION	25	25	25
BEHAVIOR	RESPONSIVE TO CARE	5	5	5
	● DEPENDENT PSYCHOLOGICALLY	10	10	10
	● BARRIERS TO CARE	10	10	10
	● CONFUSED	10	10	10
	● DISORIENTED	10	10	10
	● REPETITIVE REQUESTS	10	10	10
	● LETHARGIC	10	10	10
	● COMATOSE	10	10	10
	● DISRUPTIVE	15	15	15
	● HALLUCINATIONS/DELUSIONS	15	15	15
	● CONFLICT OF EMOTIONS	15	15	15
	● THREATENING PHYSICAL HARM	15	15	15
STATE	SELF RELIANT	4	4	4
	ROUTINE ADMISSION	7	7	7
	● SHORT TERM TEACHING & COUNSELING	7	7	7
	ASSISTANCE c̄ ADL	7	7	7
	● RESTRICTIONS	7	7	7
	PRE-OP PREPARATION	11	11	11
	● COMPLEX ADMISSION/TRANSFER	11	11	11
	POST - OP/POST-ACU (24 HOURS)	11	11	11
	● PHYSIOLOGICALLY UNSTABLE	11	11	11
	● DISCHARGE PLANNING/TEACHING	11	11	11
	● COMMUNICATIONS BARRIER	15	15	15
	● EXTENSIVE NURSING CARE	20	20	20
SUB-TOTAL ACUITY 'B'				

ACUITY 'C'	(7 - 14 - 20) SUB-TOTAL			
TREATMENT/PROCEDURE	ITEMS – FREQUENCY	TIMES		

SIGNATURES

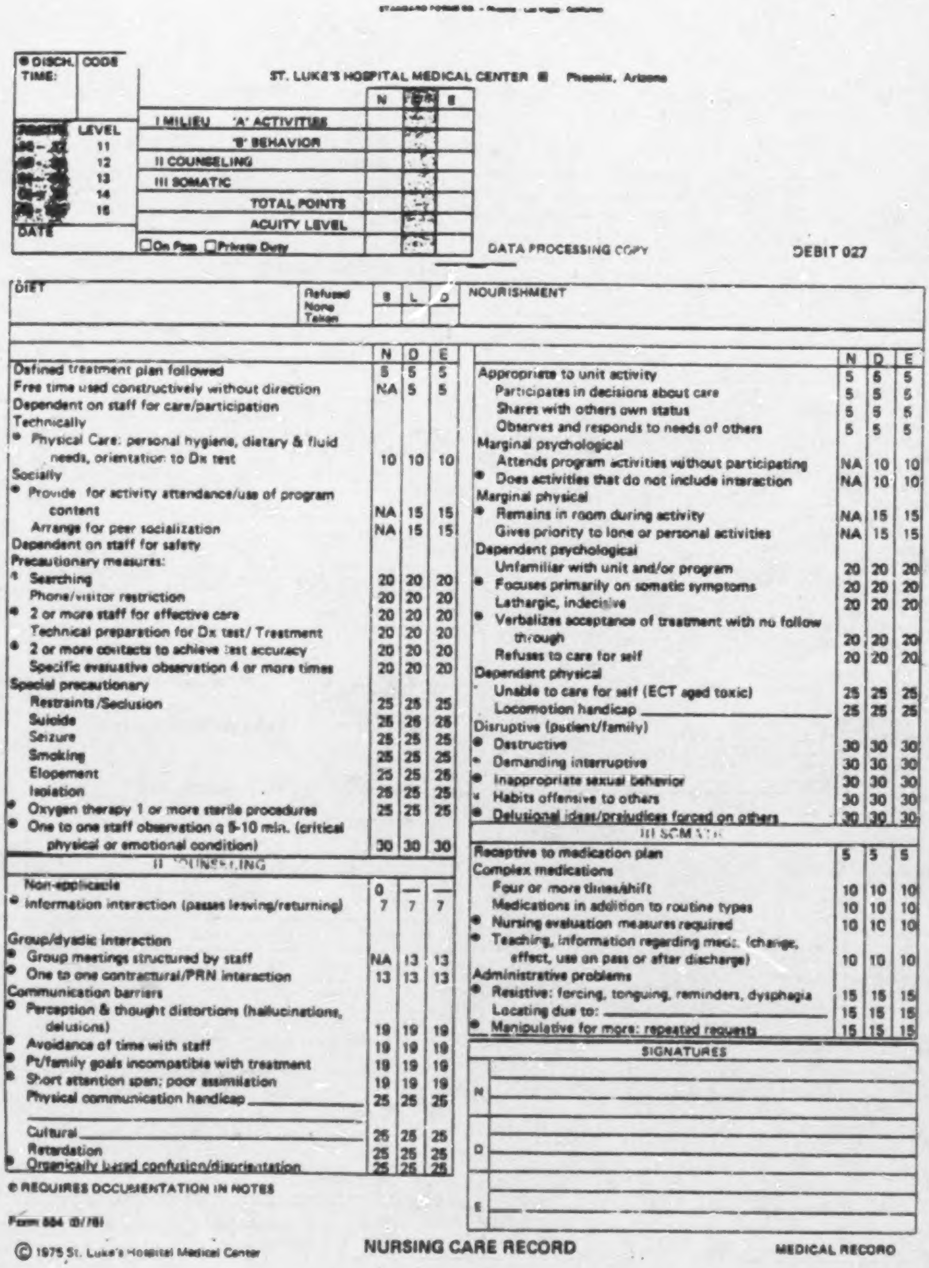
NITE	LPN/ NA	SIDE RAILS ↑	DAY	LPN/ NA	SIDE RAILS ↑	EVE	LPN/ NA	SIDE RAILS ↑
	RN	BED ↓		RN	BED ↓		RN	BED ↓

● REQUIRES DOCUMENTATION

Form 302 (7/77)
© 1977 St. Luke's Hospital Medical Center PATIENT CARE RECORD - MEDICAL/SURGICAL

MEDICAL RECORD

Exhibit B



[illegible]

● DISCH. TIME:	CODE

ST. LUKE'S HOSPITAL MEDICAL CENTER ■ Phoenix, Arizona

[redacted]	LEVEL
[redacted]	11
[redacted]	12
[redacted]	13
[redacted]	14
[redacted]	15
DATE	

	N	[redacted]	E
I MILIEU 'A' ACTIVITIES		[redacted]	
'B' BEHAVIOR		[redacted]	
II COUNSELING		[redacted]	
III SOMATIC		[redacted]	
TOTAL POINTS		[redacted]	
ACUITY LEVEL		[redacted]	
☐ On Pass ☐ Private Duty		[redacted]	

DATA PROCESSING COPY

DEBIT 027

DIET	Refused None Taken	B	L	D	NOURISHMENT

	N	D	E
Defined treatment plan followed	5	5	5
Free time used constructively without direction	NA	5	5
Dependent on staff for care/participation			
Technically			
● Physical Care: personal hygiene, dietary & fluid needs, orientation to Dx test	10	10	10
Socially			
● Provide for activity attendance/use of program content	NA	15	15
Arrange for peer socialization	NA	15	15
Dependent on staff for safety			
Precautionary measures:			
● Searching	20	20	20
Phone/visitor restriction	20	20	20
● 2 or more staff for effective care	20	20	20
Technical preparation for Dx test/ Treatment	20	20	20
● 2 or more contacts to achieve test accuracy	20	20	20
Specific evaluative observation 4 or more times	20	20	20
Special precautionary			
Restraints /Seclusion	25	25	25
Suicide	25	25	25
Seizure	25	25	25
Smoking	25	25	25
Elopement	25	25	25
Isolation	25	25	25
● Oxygen therapy 1 or more sterile procedures	25	25	25
● One to one staff observation q 5-10 min. (critical physical or emotional condition)	30	30	30
II COUNSELING			
Non-applicable	0	—	—
● Information interaction (passes leaving/returning)	7	7	7
Group/dyadic interaction			
● Group meetings structured by staff	NA	13	13
● One to one contractural/PRN interaction	13	13	13
Communication barriers			
● Perception & thought distortions (hallucinations, delusions)	19	19	19
● Avoidance of time with staff	19	19	19
● Pt/family goals incompatible with treatment	19	19	19
● Short attention span; poor assimilation	19	19	19
Physical communication handicap ________	25	25	25
Cultural ________	25	25	25
Retardation	25	25	25
● Organically based confusion/disorientation	25	25	25

	N	D	E
Appropriate to unit activity	5	5	5
Participates in decisions about care	5	5	5
Shares with others own status	5	5	5
Observes and responds to needs of others	5	5	5
Marginal psychological			
Attends program activities without participating	NA	10	10
● Does activities that do not include interaction	NA	10	10
Marginal physical			
● Remains in room during activity	NA	15	15
Gives priority to lone or personal activities	NA	15	15
Dependent psychological			
Unfamiliar with unit and/or program	20	20	20
● Focuses primarily on somatic symptoms	20	20	20
Lethargic, indecisive	20	20	20
● Verbalizes acceptance of treatment with no follow through	20	20	20
Refuses to care for self	20	20	20
Dependent physical			
Unable to care for self (ECT aged toxic)	25	25	25
Locomotion handicap ________	25	25	25
Disruptive (patient/family)			
● Destructive	30	30	30
● Demanding interruptive	30	30	30
● Inappropriate sexual behavior	30	30	30
● Habits offensive to others	30	30	30
● Delusional ideas/prejudices forced on others	30	30	30
III SOMATIC			
Receptive to medication plan	5	5	5
Complex medications			
Four or more times/shift	10	10	10
Medications in addition to routine types	10	10	10
● Nursing evaluation measures required	10	10	10
● Teaching, information regarding meds. (change, effect, use on pass or after discharge)	10	10	10
Administrative problems			
● Resistive: forcing, tonguing, reminders, dysphagia	15	15	15
Locating due to: ________	15	15	15
● Manipulative for more: repeated requests	15	15	15

SIGNATURES	
N	
D	
E	

● REQUIRES DOCUMENTATION IN NOTES

Form 884 (8/78)

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NURSING CARE RECORD

MEDICAL RECORD

ST. LUKE'S HOSPITAL MEDICAL CENTER

PATIENT CARE STUDY

DATE

PAGE

NAME

POSITION

OF

UNIT

ASSIGNMENT

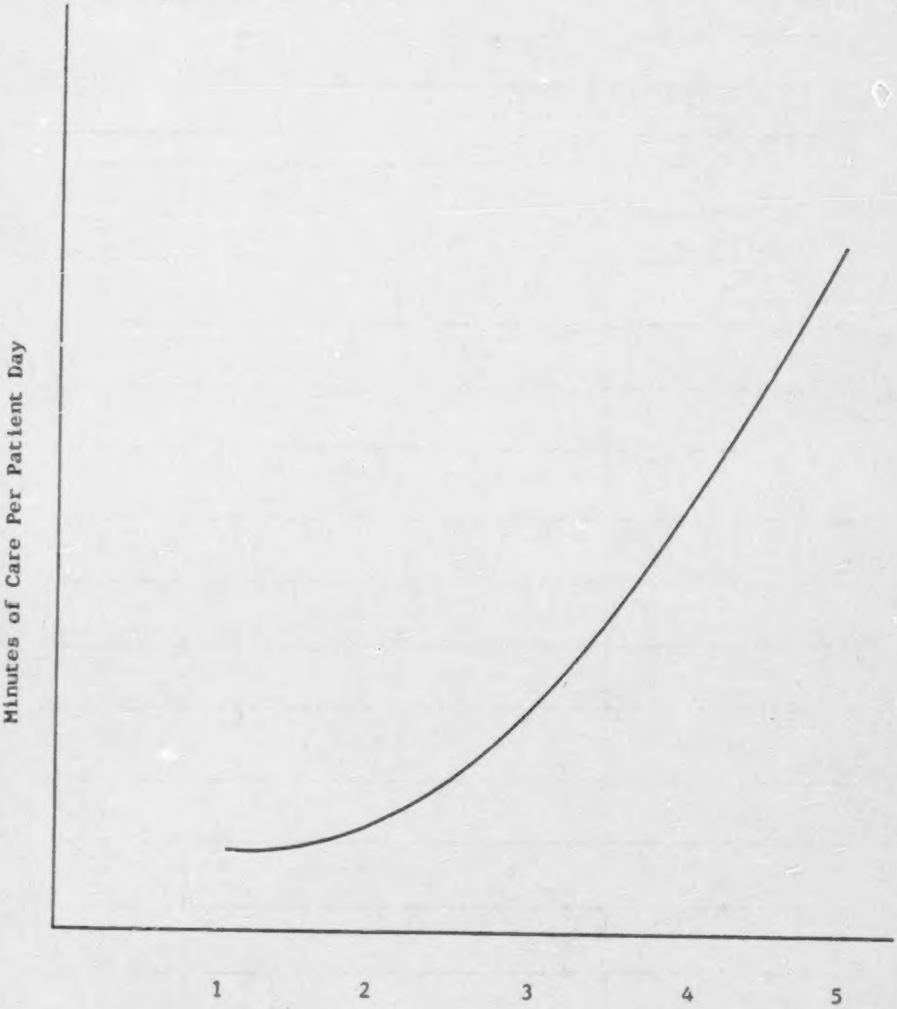
SHIFT

LEAVE COLUMNS (1), (4) AND (6) BLANK

(1)	(2) ROOM NUMBER OR PT. NAME	(3) ACTIVITY	(4)	(5) STRT TIME	(6)

TEMPORARY (1/78)

Activity Study Plot



Patient Acuity Classification

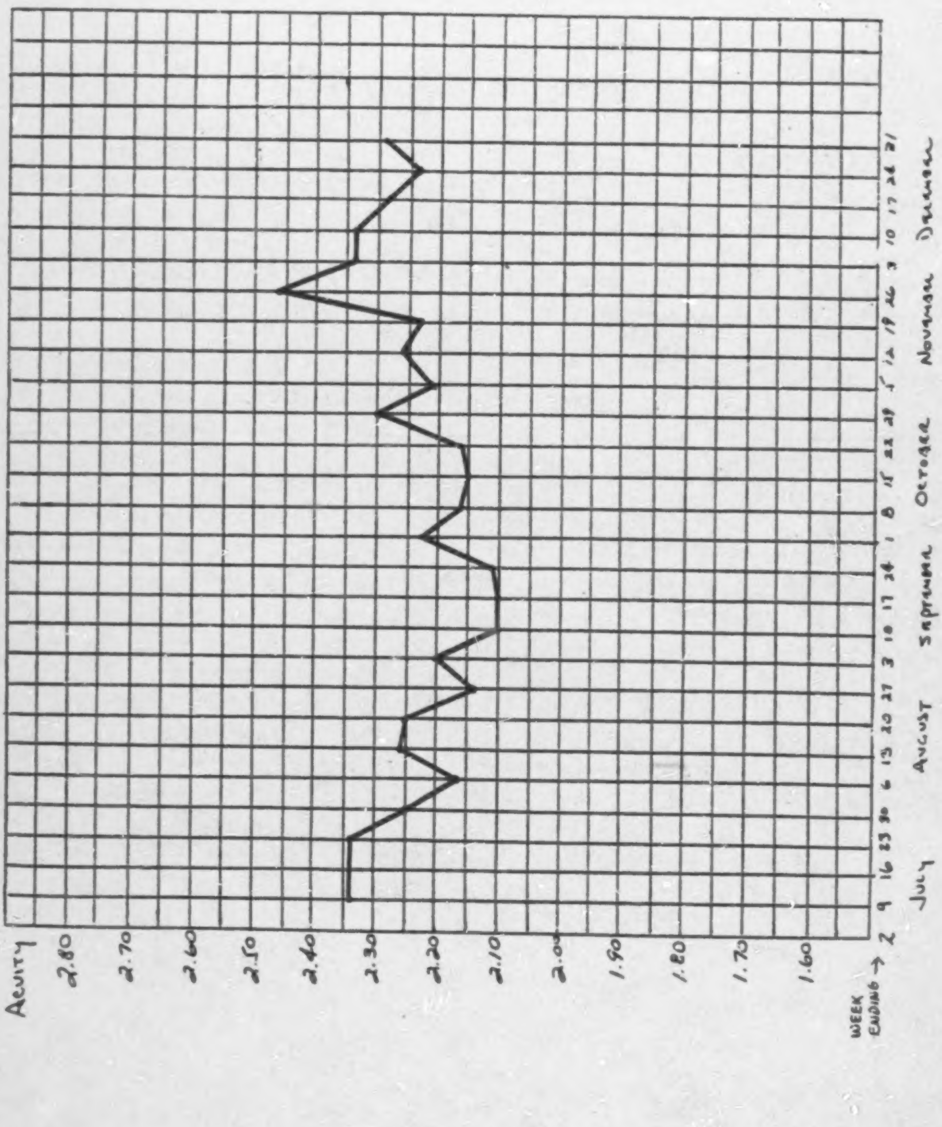
Staffing Matrix
Registered Nurses

Full time equivalent personnel required per patient day =
0.267 (I) + 0.319 (II) + 0.400 (III) + 0.533 (IV) + 0.800 (V) *

Note* (I) (II) (III) (IV) (V) = Number of patients in respective acuity classification

	Patient Acuity Classification				
Number of Patients	1	2	3	4	5
1	.267	.319	.400	.533	.800
2	.534	.638	.800	1.066	1.600
3	.801	.957	1.200	1.599	2.400
4	1.068	1.276	1.600	2.132	3.200
5	1.335	1.595	2.000	2.665	4.000
6	1.602	1.914	2.400	3.198	4.800
7	1.859	2.233	2.800	3.731	5.600
8	2.136	2.552	3.200	4.264	6.400
9	2.403	2.871	3.600	4.797	7.200
10	2.670	3.190	4.000	5.330	8.000

UNIT 7
YEAR 1977



ST. LUKE'S HOSPITAL
Phoenix, Arizona

POINTS	LEVEL		N	D	E
26- 37	1	SUB-TOTAL ACUITY 'A'			
38- 55	2	SUB-TOTAL ACUITY 'B'			
56- 70	3	SUB-TOTAL ACUITY 'C'			
71- 83	4	TOTAL POINTS			
84-103	5	ACUITY LEVEL			
DATE		● ☐ ON PASS			
		☐ PRIVATE DUTY			

		B	L	D
DIET	Refused None Partial Total			
NOURISHMENT				

	ACUITY 'A'	N	D	E
DIET	DIET CHECK	2	2	2
	NPO	2	2	2
	SELF	2	2	2
	ASSIST c̄ TRAY	5	5	5
	SIPS/CHIPS	5	5	5
	INTAKE/OUTPUT (FORCE/LIMIT)	5	5	5
	ASSIST FEED	8	8	8
	TOTAL FEED	8	8	8
	GAVAGE FEED	8	8	8
	● TEACHING FEED	8	8	8
	● COMPLEX TOTAL FEED	8	8	8
BATH/LINEN	ENVIRONMENTAL CHECK	1	1	1
	TUB s̄ HELP	1	1	1
	BATH s̄ HELP	1	1	1
	SHOWER s̄ HELP	1	1	1
	SELF-HELP (BEDSIDE)	2	2	2
	H S CARE	2	2	2
	TUB c̄ OCCASIONAL CHECK	2	2	2
	SHOWER c̄ OCCASIONAL CHECK	2	2	2
	COMPLEX H S CARE	4	4	4
	PARTIAL BATH	4	4	4
	COMPLETE BATH	4	4	4
	● COMPLEX BATH	5	5	5
	● TEACHING BATH/SHOWER	5	5	5
	● MULTIPLE BATHS	5	5	5
MOBILITY	SLEEPING/RESTING DURING ROUNDS	2	2	2
	UP AD LIB	2	2	2
	CHAIR	2	2	2
	BRP	2	2	2
	● AMBULATE c̄ HELP	5	5	5
	● BRP c̄ HELP	5	5	5
	● CHAIR c̄ HELP	5	5	5
	BEDREST c̄ BRP/COMMODE	5	5	5
	BEDREST	5	5	5
	RESTRICTIVE BEDREST	8	8	8
	● COMPLEX ACTIVITY	8	8	8
	● TEACHING ACTIVITY	8	8	8
	● THERAPEUTIC REPOSITIONING	8	8	8
	STRYKER/CIRCLE BED TURN Q ______ H	10	10	10
	● SOFT/LEATHER RESTRAINTS	10	10	10
	SUB-TOTAL ACUITY 'A'			

	ACUITY 'B'	N	D	E
MEDICATIONS	MEDICATION KARDEX CHECK	5	5	5
	ROUTINE s̄ IV's	8	8	8
	ROUTINE c̄ IV's	15	15	15
	MULTIPLE MEDS	15	15	15
	HEPARIN LOCK	15	15	15
	● TEACHING MEDICATIONS	15	15	15
	MULTIPLE PIGGYBACKS	20	20	20
	● BLOOD TRANSFUSIONS/OBSERVATION	25	25	25
	● ADMINISTRATIVE/FREQUENT INTERVENTION	25	25	25
BEHAVIOR	RESPONSIVE TO CARE	5	5	5
	● NEW ADMIT / TRANSFER / DEPENDENT PSYCHOLOGICALLY	10	10	10
	● MULTIPLE REQUESTS	10	10	10
	ALTERED STATES OF AWARENESS			
	● LETHARGIC	10	10	10
	● DISORIENTED	12	12	12
	● HALLUCINATIONS/DELUSIONS	15	15	15
	● BARRIERS TO CARE	15	15	15
	● ATTENTION SEEKING BEHAVIOR	15	15	15
	● DISRUPTIVE	15	15	15
	● THREATENING PHYSICAL HARM	15	15	15
STATE	RESPONSIBLE FOR PERSONAL CARE	4	4	4
	● SHORT TERM TEACHING/COUNSELING	7	7	7
	ASSISTANCE WITH ADL	7	7	7
	● RESTRICTIONS	7	7	7
	PRE-OP PREPARATION	11	11	11
	● ADMISSION/COMPLEX TRANSFER	11	11	11
	POST-OP/POST-ACU (24 HOURS)	11	11	11
	● DISCHARGE PLANNING/TEACHING/CARE PLANNING	11	11	11
	● PHYSIOLOGICALLY UNSTABLE	15	15	15
	● COMMUNICATION BARRIER/SENSORY IMPAIRMENT	15	15	15
	● EXTENSIVE NURSING CARE	20	20	20
	SUB-TOTAL ACUITY 'B'			

ACUITY 'C'	(7 - 14 - 20) SUB-TOTAL			
TREATMENT/PROCEDURE	ITEMS – FREQUENCY	TIMES		

SIGNATURES

NITE	LPN/ NA	SIDE ↑ RAILS	DAY	LPN/ NA	SIDE ↑ RAILS	EVE	LPN/ NA	SIDE ↑ RAILS
	RN	BED ↓		RN	BED ↓		RN	BED ↓

● REQUIRES DOCUMENTATION

Form 302 (1-82)
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PATIENT CARE RECORD—MEDICAL/SURGICAL

MEDICAL RECORD

I

ST. LUKE'S HOSPITAL MEDICAL CENTER ■ Phoenix, Arizona

POINTS	LEVEL
15 - 37	11
38 - 50	12
51 - 62	13
63 - 75	14
76 - 85	15
86 - 100	16
POLICY	17
DATE	

	N	D	E
I MILIEU 'A' ACTIVITIES			
'B' BEHAVIOR			
II COUNSELING			
III MEDICATION			
TOTAL POINTS			
ACUITY LEVEL			
● ☐ ON PASS			
☐ PRIVATE DUTY			

DIET	Refused None Taken	B	L	D	NOURISHMENT

I MILIEU

'A' ACTIVITIES	N	D	E
Defined treatment plan followed	5	5	5
Free time used constructively without direction	NA	5	5
Dependent on staff for care participation			
Technically			
● Physical Care: personal hygiene, dietary & fluid needs, orientation to Dx test	10	10	10
Socially/Educationally			
● Provides for activity attendance/use of program content	NA	15	15
● Arrange for peer socialization	NA	15	15
Dependent on staff for safety			
Precautionary measures			
● Searching	20	20	20
Phone list for room restriction	20	20	20
● 2 or more staff for effective care	20	20	20
● Technical preparation for Dx test/Treatment	20	20	20
● 2 or more contacts to achieve task/results	20	20	20
● Specific evaluative observation 4 or more times	20	20	20
Special precautionary			
● Restraints/Seclusion	25	25	25
● Close watch	25	25	25
Situational Precautions			
● Smoking/Flammables	25	25	25
● Elopement	25	25	25
● Seizure	25	25	25
● Isolation	25	25	25
● Oxygen therapy 1 or more sterile procedures	25	25	25
● One to one staff observation < 15 min.	30	30	30

II COUNSELING

Not applicable	0		
● Information interaction (passes leaving/returning)	7	7	7
Group/dyadic interaction			
● Group meetings structured by staff	NA	13	13
● One to one contractural/PRN interaction	13	13	13
Communication barriers			
● Perception & thought distortions (hallucinations, delusions)	19	19	19
● Avoidance of time with staff	19	19	19
● Pt/family goals incompatible with treatment	19	19	19
● Short attention span; poor assimilation	19	19	19
Physical communication handicap ______	25	25	25
Cultural ______	25	25	25
Retardation	25	25	25
■ Confusion/disorientation	25	25	25

'B' BEHAVIOR	N	D	E
Appropriate to unit activity	5	5	5
Participates in decisions about care	5	5	5
Shares with others own status	5	5	5
Observes and responds to needs of others	5	5	5
Marginal psychological			
● Attends program activities without participating	NA	10	10
● Does activities that do not include interaction	NA	10	10
Marginal physical			
● Remains in room during activity	NA	15	15
● Gives priority to lone or personal activities	NA	[illegible]	[illegible]
Dependent psychological			
● Unfamiliar with unit and/or program	20	20	20
● Focuses primarily on somatic symptoms	20	20	20
● Lethargic/indecisive/passive	20	20	20
● Verbalizes acceptance of treatment with no follow through	20	20	20
● Does not care for self	20	20	20
Dependent physical			
● Unable to care for self (ECT aged toxic)	25	25	25
Locomotion handicap ______	25	25	25
Disruptive (patient/family)			
● Destructive	30	30	30
● Demanding/interruptive	30	30	30
● Inappropriate sexual behavior	30	30	30
● Habits offensive to others	30	30	30
● Delusional ideas/prejudices forced on others	30	30	30

III MEDICATIONS

Receptive to medication plan	5	5	5
Complex medications			
Four or more times/shift	10	10	10
● Nursing evaluation measures required	10	10	10
● Teaching, information regarding meds. (change, effect, use on pass or after discharge)	10	10	10
● Resistive: forcing, tonguing, reminders, dysphagia	15	15	15
Locating due to: ______	15	15	15
● Manipulative for more: repeated requests	15	15	15

NURSE'S SIGNATURES		
NIGHT	DAY	EVENING

● REQUIRES DOCUMENTATION IN NOTES

Form 564 (8/81)

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NURSING CARE RECORD – BEHAVIORAL HEALTH

MEDICAL RECORD

Chairman **Stark**. Thank you.

Do the Catholic hospitals have any information why California costs so much more than the rest of the world?

Mr. Cox. I think there are probably a variety of factors for that.

Chairman **Stark**. I hear that.

Mr. Cox. Dr. Mongan listed a whole number of areas earlier in his testimony that might be contributing to the problem, but I think a kind of a common-sense approach is to asking why it is more expensive to get a hotel room, food, and transportation in San Francisco than it is in Birmingham, AL.

We don't know all the reasons for that, but it is. I think it is——

Chairman **Stark**. You have been to both places?

Mr. Cox. I have been to both places.

Chairman **Stark**. I want to tell you that either place is preferable to a prostectomy—how's that? [Laughter.]

Or other things that I have here on this list.

Mr. Cox. That's right.

I think there are other factors, too. Utility costs are different in different States. The cost of generating the electricity and other things——

Chairman **Stark**. But take all that, wage rates, utility costs.

Mr. Cox. Food, and so on.

Chairman **Stark**. But all that can't double and triple.

Mr. Cox. It can in the area especially of wage indexes if they are not properly constructed they can really skew the——

Chairman **Stark**. But the cost of a procedure is what we are talking about. You go in with no insurance, you shop around, go to Kaiser and go to Merit and whatever other hospital you want to go to, and it is costlier out there. Maybe they do things differently.

Mr. **Lockwood**. I believe there are two major factors, one is this whole thing that deals with cost of living that you just finished talking about.

Chairman **Stark**. That we can adjust all right. That is easy.

Mr. **Lockwood**. The areas of the coasts seem to be higher cost for a variety of reasons.

Chairman **Stark**. Not necessarily higher than Washington, DC.

Mr. **Lockwood**. That is pretty close to the East Coast. I am talking about the center of the country which seems to have lower costs than the other parts.

Chairman **Stark**. I see.

Mr. **Lockwood**. But the other area is practice patterns, I believe.

Chairman **Stark**. How would you score that? Would you say half of it is practice patterns?

Mr. **Lockwood**. I couldn't estimate.

Chairman **Stark**. Sooner or later we have to find that out, it seems to me, so you can begin to lump these. You can deal with wages and fuel and you can deal with the cost of a bed pan and deal with construction costs. Interest rates are pretty much the same.

Mr. Cox. Mr. Chairman, respectfully those issues are far more difficult to deal with than we realize. I think we can identify differences in costs, but to build in a mechanism for it is——

Chairman **Stark**. How about there being no difference in a procedure greater than a coach round trip air fare from the farthest two points of the United States so that if you can get round trip coast to coast for $600, that any procedure that is more than $600 difference in California, you know, you can fly back here and get it done. That would make the airlines happy.

Thank you, gentlemen. You can expand on this if you wish, but I have to vote.

Mr. **Lockwood**. The only point I was going to make is we shouldn't be surprised about the practice pattern differences because length of stay across the Nation has been substantially different in various parts, and it speaks just to the way doctors practice medicine.

Chairman **Stark**. Well, that is a good point.

Is that all the witnesses?

The committee stands in recess.

[Whereupon, at 2:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Houston, TX, *June 3, 1985.*

Representative Charles B. Rangel,
Rayburn House Office Building,
Washington, DC.

Dear Representative Rangel: I would like to testify at the hearing on "Medical Education Pass-Through" that has been scheduled for June 3, 1985.

I am extremely interested in finding ways of lowering health care costs without lowering its high quality and without interfering with medical advances.

My opinions to you today are *not* as a member of the American Medical Association, Texas Medical Association, Harris County Medical Society, American College of Obstetricians and Gynecologists, or of the Houston Surgical Society, of which I am the current President. Instead, my opinions to you today are as a health care consumer that has two elderly parents, a wife, four sons, and a daughter-in-law that are all health care consumers. I say also that these opinions have been formulated by a background that includes:

Two years as a salaried U.S. Navy physician, Lt. Cdr., stationed at U.S. Marine Station Hospital, Cherry Point, North Carolina, where I was Chief of Obstetrics and Gynecology and Head of the Dependents Clinic.

Six years in medical research and teaching at Baylor University College of Medicine, Houston, Texas.

Eighteen years in private practice in the Texas Medical Center, Houston, Texas, one half of which has been in teaching hospitals and one half in nonteaching hospitals.

My concerns that I would like to address today consist of lowering health care costs by:

(1) Prohibiting Medicare payments for graduate medical education.

(2) Prohibiting proposals to give states block grants to fund graduate medical education.

(3) Prohibiting proposals to federally fund three years of residency training.

(4) Prohibiting the leveraging of the system that would create more primary care residencies.

(5) Prohibiting the proposal to have the Medicare hospital trust fund contribute to the first year of residency training.

(6) Prohibiting the use of any federal funds for residency training except for part B doctors' coverage for those doctors in residency training that threat Medicaid and Medicare patients in city, county, or state indigent hospitals where the resident doctors are ones actually responsible for the patient's care.

(7) Prohibiting the development of a severity-of-illness index, which teaching hospitals have sought.

I would now like to address these concerns in detail. Why should Medicare funds be used for graduate medical education when its intended use is for paying health care costs for the elderly. I say to restrict the use of Medicare funds to its intended purpose. Internship and residency programs are simply extensions of medical school educational programs. The beneficiaries of these educational programs are not the elderly sick, but instead are:

(A) *The Interns and residents themselves*, by furthering their educations, increasing their knowledge and increasing their future income potential.

(B) *The practicing physicians at the teaching hospitals* who benefit tremendously from the help and assistance of the interns and residents by:

(1) free surgical assistants during surgery.

(2) free admission workups with histories and physicals on their patients including the necessary dictations and paper work.

(3) free discharge summary dictation.

(4) free rounding on their patients.

(5) free nightime coverage of their inpatients and outpatients by the interns and residents sleeping in the hospital, frequently being awakened by phone calls, trips to the floors to check on patients, and frequently going to the Emergency Room to see patients sent in by their private physicians who remain at home, permitting the intern and resident to take care of a large percentage of their night time and weekend problems.

(6) free coverage of labor and delivery patients, many times actually delivering the patient when the private physician does not make it in time or cannot be located.

I say that the cost of graduate medical education should be borne by those who benefit from it. First of all, I advocate that the private physicians at the teaching hospitals who benefit from all the fine assistance from the interns and residents should pay for it. I practice at a nonteaching hospital and I pay my surgical assistant $18.63 per hour, my scrub nurse $18.63 per hour, and my graduate nurse that dictates my discharge summaries $18.63 per hour. Everytime that the intern and/or resident physician does a service for a private physician in a teaching hospital, he or she should be reimbursed by that physician, whether its seeing a patient in the emergency room or getting up at night to check on a patient that the nurse in concerned about. They should be reimbursed for every delivery of a child that is necessary when the private obstetrician does not make the delivery in time.

Another possible solution would be for the entire medical staff, that benefits from the presence of the interns and residents, to voluntarily or involuntarily reestablish a residency fund that would adequately pay salaries for the interns and residents.

If it is true that teaching hospitals receive "sicker patients" than nonteaching hospitals, then let this discrepancy be made up by the payment for the DRG illness rather than increasing reimbursements for all the DRG's just because the hospital is a teaching hospital.

Secondly, if adequate reimbursement of interns and residents cannot be accomplished with the above recommendation, I say to extend the Health Education Assistance Loans program to interns and residents, providing financial aid to them, as it does to medical students. Since this is a government guaranteed but not government funded program, I believe that it would be acceptable by all parties concerned.

For those teaching hospitals that are city, county, or state indigent hospitals where there are no private physicians that would benefit from interns' and residents' help, the funding of salaries could be by Part B Medicare and Medicaid payments for actual services performed. Any additional funding required should come from the city, county, or state governments themselves, not from Medicare funds.

Lastly, I would propose another possible source of funding for graduate medical education. Each teaching hospital could set up a residency training fund from private sources such as:

(1) Alumni of the respective residency training programs, who out of gratitude for the training they received, would be motivated to contribute.

(2) Corporations whose profits benefit from what physicians do, i.e.:

(a) Life insurance companies whose policyholders' longevity continues to increase yearly resulting in increased profits (see exhibit A).

(b) Pharmaceutical companies whose profits increase because of prescriptions written by physicians (see exhibit B).

(3) Private foundations.

I would make a plea to immediately stop all present plans to leverage the medical education system. I want to make a plea to open up the system so that any deserving student that wants to become a physician has an opportunity to go to medical school. When he finishes medical school, he should have an opportunity to try to become whatever kind of physician he wants to become, whether eye surgeon, plastic surgeon, or primary care physician.

Presently, 20 percent of all physicians in the United States are foreign medical graduates. Many of oiur fine college graduates are having to go out of the country to a foreign medical school because of an inability to gain entrance to one here in this country. Even a larger number give up trying to gain entrance after being turned down and switch to other fields.

I say that this is a shame and disgrace. Every college graduate that wants to go to medical school should have an opportunity to do so. So much competition exists for the restricted number of available spots that too much reliance is placed upon grade point average and MCAT scores. I would like to see it easier to become a doctor, so much so that any college graduate that wants to can give medical school a try.

People say, "well what about the doctor glut?", "we already have too many doctors and too many more coming "down the pipe" (still in training)". I say the more doctors we have, the more competition there will be with lowering of health care costs. I would like to remind people that there are still entire counties in this country without a single physician. There are twice as many lawyers in the state of Texas as there are physicians, and twice as many lawyers in Harris County, Texas, than there are physicians.

	Lawyers	Physicians
Texas	40,000	25,750
Harris County	12,000	6.123

I say that it should be just as easy for a college graduate to get into medical school as it is for him to get into law school.

In closing, once again I would like to urge you to preserve Medicare funds for their intended use of paying health care costs of the elderly. Federal subsidies for health professions training, which began in 1965, should be discontinued. The supply of physicians per capita has grown 49% between 1965 and 1983, and surpluses for most health care disciplines are projected for the 1990's. With the surplus of physicians coupled with decreased occupancy rates of hospitals (caused by cost containment policies during the past several years, see exhibit B), there has developed a fierce competition between doctors for patients, and between hospitals for patients with television and radio commercials, and newspaper advertisements with some teaching hospitals advertising steak and shrimp dinners (see exhibit C), as well as free limosince service home at time of discharge, and hors d'oeuvres for guests. Discounts on services are being offered by the different preferred provider organizations (P.P.O.'s) associated with the different hospitals and hospital chains. It is estimated there are 4,000 to 6,000 empty hospital beds each day in Harris County (see exhibit D). With this as a background, why should Medicare funds be used to help the teaching hospitals when they are competing so actively against the nonteaching hospitals. I say that it is unfair for Medicare funds to be used to help subsidize the teaching hospitals when they are so actively competing with the nonteaching hospitals for patients. You may not be aware of it, but the leading hospital chains, like Hospital Corporation of America and Humana, are seeking to own or manage teaching hospitals (see exhibit E).

In a nutshell, the nonteaching hospitals are competing against the teaching hospitals and it is unfair competition since the teaching hospitals are being subsidized by Medicare funds that were intended for health care costs for the elderly. I say let us put a stop to the entire $1.3 Billion indirect aid for health professions education, leaving only the revolving fund for Health Education Assistance Loans.

I am very sorry that my request to testify was denied but I do appreciate having the opportunity to have my recommendations included in the printed record of the hearing.

Sincerely yours,

J. ALAN ALEXANDER, M.D.

[Exhibit A]

Firm: [1]	*Assets (Billions)*
Aetna	$48
Cigna	35
Travelers	33
American General	18
Lincoln National	11
Transamerica	11
American International	11
CNA Financial	10

	Assets
Continental Corp.	9
Kemper Corp.	7

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[1] The rankings are for investor-owned insurance companies.

[From the Houston (TX) Chronicle, May 2, 1985]

American General Has Record Quarter

(By Tom Scott)

American General Corp., the nation's fourth largest shareholder-owned insurance company, is profiting from its enormous acquisitions over the past few years, even though it has piled up a mountain of debt.

The Houston-based Insurance company employs 16,000 people and has 21 million customers. What started in 1926 as a Texas fire and casualty insurer now reports assets of $20 billion and claims to invest an average of $15 million every day.

The company's first quarter results for 1985 are the best in history, said Chairman Harold S. Hook at American General's annual shareholder's meeting, Wednesday at Texas Commerce Center's McDade Auditorium.

"This is particularly significant since quarter to quarter results are now comparable for the first time in three years, due to the completion of American General's major acquisition program in 1984," Hook said.

For the first quarter, American General reported net income of $122.82 million, equal to 88 cents per share, compared with $100.3 million, or 77 cents, for the first quarter last year. Revenue for the first quarter was $1.35 billion, compared to $1.35 billion in 1984.

American General's subsidiaries are primarily in the life, health, annuity and property liability insurance businesses. Other subsidiaries are involved in consumer credit, real estate development and the mortgage banking business.

In 1984, American General acquired Gulf United Corp.'s insurance operations for $1.2 billion. In 1982, it acquired Credithrift Financial Inc. and NLT Corp.

The NLT acquisition was estimated to have increased operating earnings by $14 million in 1982 and $116 million in 1983. The Gulf United acquisition increased 1984 operating earnings by $79 million.

As a result of those purchases, American General is among the most highly capitalized financial organizations in America. The company's total capital increased more than 200 percent from $1.4 billion at year-end 1981 to more than $4.2 billion at the end of 1984. (The total capitalization of a company is the sum of all securities, including short-term debt, long-term debt, preferred stock, warrants and common stock).

American General's current debt to equity ratio is estimated at 26 percent to 27 percent.

Morgan Stanley & Co., Inc., a New York investment bank, recently put American General on its recommended purchase list, saying the company will achieve per share profits of $3.25 this year (a 61.7 percent advance) and a further 20 percent gain to $3.90 next year.

"Of the 10 largest shareholder-owned insurance organizations in the United States, American General has been able to achieve the second-best five-year compound growth rate in per share total return (21.7 percent)," said Morgan Stanley analyst Norman L. Rosenthal.

In three years, American General has moved from a medium-size insurance underwriter to the fourth largest investor-owned insurance concern, without the impairment of earnings that such rapid growth customarily entails, Rosenthal said.

The firm is the nation's largest writer of home-service life insurance, among the top 10 writers of ordinary life insurance and a major market force in group life and health insurance, property casualty insurance and consumer finance.

Morgan Stanley estimates, that consolidation of American General's operations will save $65 million pretax in selling, general and administrative expenses in 1986.

Consolidation of American General will continue and losses in property casualty insurance have turned around due to an average 25 percent increase in premiums, Hook told shareholders.

Morgan-Stanley expects Maryland Casualty to post a major profit turnaround this year and post a $60 million to $65 million profit. The unit lost about $60 million in 1984.

While the federal government does not regulate the insurance business, the company notes in its annual report that "federal initiatives," such as changes in pension regulations or controls on medical costs, can significantly affect the bottom line.

Currently, one issue of particular concern is the possible repeal of the antitrust exemption for the insurance business.

"If this exemption is eliminated, it will substantially affect the way premium rates are set by all property-liability insurers," the annual report states.

Additionally, tax changes by the U.S. Treasury Department will affect the insurance industry. The current tax proposal proposed by Treasury would tax policyholders on a portion of the increase in cash values of permanent life insurance policies. The imposition of such a tax would drastically curtail the sale of permanent life insurance.

The proposal also would discourage the expansion of group life, health and pension benefits by taxing the premiums paid by employers, thus reducing or eliminating plans that are particularly beneficial to people in lower income brackets, the company's annual report said.

Hook said the key financial results for 1984 were that assets increased 27 percent to $19.2 billion and revenues increased 36 percent to $5.4 billion. Total return to shareholders, including stock price appreciation and the dividend yield was 18.8 percent for 1984. American General is traded on the New York Stock Exchange under the symbol AGC. It closed Wednesday at 31⅛, unchanged.

DEVELOPMENT COMPANY FORMED

Metropolitan Life Insurance Co. and the Vantage Companies have formed MetVan Property Co., a development organization that will buy or build industrial and commercial properties for long-term investment in Houston and across the United States.

The company is capitalized at $100 million in cash and equity capital put up by Metropolitan and Vantage.

North Belt Business Park is a Houston project developed by Vantage and Metropolitan and offers more than 600,000 square feet of office and warehouse space on a 76-acre site on the North Belt near Intercontinental Airport.

The two firms are also partners in office buildings in Dallas and Denver, industrial parks in Chicago and Minneapolis, a distribution center in Tampa and an office park in Memphis.

John F. Eulich, Vantage chairman, and Henry J. Knapek, Houston division president, note that MetVan has nothing immediate planned for the Houston area and will start operations in Atlanta and elsewhere in the Southeast.

Vantage has developed more than $5 billion worth of commercial and industrial property in Houston and elsewhere since 1959 and operates a Houston divisional headquarters in its own building at 10777 Westheimer.

Metropolitan Life is the second largest company dealing in life insurance and financial services and has total assets of more than $81 billion, including commercial and other properties, joint ventures and mortgage loans in a real estate investment portfolio valued at $20 billion.

[Exhibit B]

[From the Houston (TX) Post, Apr. 29, 1985]

IS JOB OUTLOOK FAVORABLE IN HEALTH CARE FIELD?

(By Joyce Lain Kennedy)

(Q) My daughter was encouraged to use a school computer to identify career choices. Her results point toward work in the health field. The computer says the outlook is very favorable for health jobs. With today's emphasis on cutting medical costs, is this the case?

(A) Yes and no. Long-term prospects for a strong job market in health are bright, considering that as the nation's population ages, it will need more health care. But the health job market changes rapidly and even the best computer guidance systems aren't updated frequently enough to reflect current happenings.

And many things are happening in health; some positive, some negative. New cost-containment policies during the past several years have hurt hospital industry, where the majority of health care workers are employed.

In Texas, 40 hospitals have closed in the past two years. Health observers predict that as many as 1,000 of American hospitals may close by 1990.

By no means an isolated example, a recent study of 1,000 health care workers who lost their jobs in Birmingham, Ala., showed 95 percent of the layoffs were in lower-level nursing areas: licensed practical nurses, orderlies and two-year associate-degree registered nurses.

After two decades, health care growth has slowed down. Industry, labor and insurance companies have organized to control runaway costs by increasing deductible ceilings, which encourages employees to price-shop medical care and to complain about inflated charges.

Moreover, the government's Medicare program for the aged, which pays 40 percent of all hospital bills, has shifted to a prospective payment system. Hospitals are paid a set free per diagnosis, not what they say treatments cost.

All this means that people are going to hospitals less often and staying fewer days. That's a big reason why the need for lower-echelon nursing care diminished.

Another trend—one that will make working at many hosptials more bureaucratic than ever—is the commercialization of hospitals by private, profit-making companies.

Send career questions for possible use in this column to Joyce Lain Kennedy, P.O. Box 3090, Carlsbad, Calif. 92008. Sorry, the volume of mail makes personal replies impossible.

[Exhibit C]

NASHVILLE, TENN. (AP)—The couple sits at a linen-covered table toasting each other and eating steak by candlelight. But the setting is a hospital room, where hours before the woman gave birth to a daughter, now snoozing nearby.

[Exhibit D]

[From the Houston (TX) Post May 30, 1985]

PRIVATE HOSPITALS FAVOR PLAN OF CONTRACTING OUT EMPTY BEDS—HARRIS COUNTY HOSPITAL DISTRICT STUDIES HERMANN OFFER

(By Pete Brewton)

Officials with a number of private hospitals in Houston on Wednesday followed the lead of Hermann Hospital, saying they would like to have some of their empty beds used by the Harris County Hospital District.

"Our position is the same as most hospitals—we are certainly willing to do it, if the mechanics can be worked out," Ken Wine, senior vice president of the Memorial Hospital system, said Wednesday.

Every hospital official contacted by The Post Wednesday said they have empty beds available for use by the hospital district.

"We have plenty of beds available," said Harold Foitik, with American Medical International, a large hospital chain that has 11 hospitals in the Houston area.

Foitik said officials with his company are now reviewing the possibility of contracting empty beds out to the hospital district.

HCA HAS BEDS

Dick Kraus, an official with Hospital Corporation of America, another large hospital chain, which also has 11 hospitals in the Houston area, has told The Post that HCA would be willing to work with the hospital district to provide beds.

A spokeswoman for St. Joseph Hospital said, "we are interested in the idea," noting that the 840-bed hospital is no longer using 100-130 of these beds.

St. Elizabeth Hospital, located in the heart of the Fifth Ward, one of the poorest areas of Houston, has made a formal proposal to the hospital district to provide 30 to 50 beds per day. The hospital also has expressed interest in providing outpatient services to the hospital district.

In addition, York Plaza Hospital in northeast Houston and Riverside Hospital in the Third Ward, have made requests to provide the hospital district with beds.

The occupancy rate at area hospitals is down considerably over previous years and is not expected to increase soon. It is estimated there are 4,000 to 6,000 empty hospital beds each day in Harris County.

Most hospital experts attribute this decline to structural changes in the way Medicare payments are made and increased usage of outpatient services, where the patient is not admitted into a hospital.

Hospital district officials are now studying the 200-bed Hermann offer, with such questions as staffing and cost to be worked out. If the hospital district accepts the

Hermann offer and goes ahead with its plan to build two new hospitals, there would be little need by the district for other beds.

The two new hospitals would provide 850 beds—about 100 more than the existing number at the hospital district—at an estimated cost of $700 million over the next 30 years.

It is doubtful the district has the money to build the two planned new hospitals and use the 200 beds in Hermann. Some hospital district officials are now talking about scaling down the two new hospitals, rather than renovating the two existing hospitals and contracting for private beds—which a citizens' coalition opposing the construction of the new hospitals has been urging.

Some hospital and coalition officials are questioning the existence of the hospital district, saying poor people should be able to choose their own doctors and hospitals and should be able to go to the hospitals closest to their homes.

POOR LOSE DIGNITY

"Why should we send all the poor people to one hospital?" questioned Sister Mary Damian, administrator of St. Elizabeth Hospital.

Such segregation "robs the poor of their dignity," Sister Damian said. She said poor people should be able to go to hospitals in their communities so that they could be close to their families.

A private physician who came up with the Hermann plan along with Don Walker, president of Hermann, echoed Sister Damian's feeling. This doctor, who asked that his name not be used, said "patients have a right and dignity at a time of illness to be treated at a community hospital, except for catastrophic diseases."

Such a system, this doctor said, would allow young medical students and residents to see and treat indigent patients in a community hospital setting.

Dick Durbin, administrator of the hospital district, which operates the tax-supported medical facilities for the eligible poor here, said he is uncertain how such a system would work.

He did admit that if the federal-state Medicaid program was adequate enough to take care of all the poor in the Houston area, there would be no need for the hospital district. The patients would pick their own doctors and hospitals which accepted Medicaid.

The hospital district operates Ben Taub Hospital in the Texas Medical Center, jefferson Davis Hospital, west of downtown, and Quentin Mease Hospital in the Third Ward. It plans to replace Ben Taub with a new hospital and tear down Jefferson Davis.

The district wants to build a 300-bed hospital in northeast Houston near Loop 610 and Lockwood, located in and surrounded by the 100-year flood plain. District officials have acknowledged flooding problems but say the hospital is needed in that poor area.

[EXHIBIT E]

In another important development, the leading chains are seeking to own or manage teaching hospitals. Teaching hospitals, which always want the most advanced medical equipment, have a great appetite for capital, one chain executive points out. So the chains proffer money, along with management. From the chains' standpoint, teaching hospitals on the forefront of new treatment methods attract patients from a wide geographical base. Ms. Scheuerman sees another implication: "In the long term, [the chains] will be able to train physicians to deal in the proprietary environment. At teaching hospitals, they're developing a pool of physicians with a business orientation, a core to draw from and pull into their hospitals."

STATEMENT OF CLARICE JONES, CHAIRPERSON, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

INTRODUCTION

Good morning, Mr. Chairman, my name is Clarice Jones and I am Chairperson of the Board of Directors of the American Association of Retired Persons. On behalf of the 18 million members of the AARP, I want to thank you for this opportunity to state the Association's views on the Medicare DRG prospective payment system. The Medicare DRG system is 19 months old now and all non-exempt hospitals participating in Medicare have begun the phase-in towards national DRG rates. Thus it is a good time to step back, take a look at what is happening to patients under DRGs, and make necessary adjustments to the system.

My testimony today identifies three areas of concern about the implementation and operation of the DRG system so far: (1) The Health Care Financing Administration's (HCFA) failure to adequately monitor and correct for the economic incentives under DRGs to skimp on quality care; (2) the serious lack of policy coordination and support of DRGs by contemporaneous HCFA policies; and, (3) the exacerbation of DRGs problems by ill-conceived, large reductions in the federal health budget.

Following the discussion of these points, AARP makes several recommendations to improve the administration of DRGs, including: changes in the Medicare appeals process, improved access and coverage for beneficiaries needing post acute care services, and innovative efforts by peer review organizations (PROs) to monitor and enforce standards for quality care.

HOSPITAL INCENTIVES UNDER DRG'S

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old cost plus system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospitals interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, however, those incentives are gone.

Under DRGs, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon as possible in ordr to maximize their "profit." Moreover, new administrative rules and policies under DRGs limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, HCFA requires PROs to reduce identified procedures (the procedures vary from state to state) by specific amounts. PROs will be evaluated by HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, these numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Another example of a government requirement that places Medicare beneficiaries in jeopardy is HCFA's policy directive permitting hospitals to inform Medicare patients before admission, at admission, or during the hospital stay that certain services may not be covered by Medicare and that the patient is liable for payment if he or she goes forward with the treatment. This directive is a major new loop-hole in Medicare, and will result in greater out-of-pocket costs to beneficaries.

Thus, the incentives inherent in the DRG system combined with the new rules implementing it, substancially alter Medicare patients' rights under DRGs. This combination of structural incentives and administrative incentives jeopardize beneficaries in two ways: (1) there is greater jeopardy to individual health status from skimping on services, and (2) there is greater financial jeopardy for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required.

The Administration and the Congress must understand that these incentives are hurting Medicare patients. Although only anecdotal evidence is currently available to describe the effect of DRGs on patients, such evidence continues to mount.

EVIDENCE THAT DRGS ARE HARMING PATIENTS

In February 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about problems of early discharge and lack of post acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. Fortunately, the witness was knowledgeable about DRGs and was able to fight the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and, therefore, are much more likely to acquiesce in the hospital's decision.

On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting Office on the impact of Medicare's new prospective payment system on post hospital care. The report showed that Medicare patients are being discharged "quicker and sicker," too often with no place to go.

The American Association of Retired Persons is also trying to evaluate the scope and breadth of the problems affecting patient care under DRGs. The Association has receive over 200 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. The two stories that follow are illustrative of the anxiety and frustration encountered by Medicare beneficiaries and their families under the DRG prospective payment system.

The first letter is from the daughter of a Medicare beneficiary in New York City. She writes that her father was hospitalized for cancer, the primary location of which was unknown but which resulted in a brain tumor requiring radiation treatment. Two weeks of radiotherapy left him in a very weakened condition. Nevertheless, near the completion of the radiotherapy he was given large doses of four toxic chemotherapy drugs. The morning following completion of the chemotherapy he received his final dose of radiation and was discharged.

Within three days he was readmitted with a fungal infection in his mouth and throat which prevented him from eating and drinking. After ten days he was discharged over the objections of his wife that he was too weak to go home.

Within two days of the second discharge he was readmitted to the hospital with pneumonia. After eight days in the hospital he was again scheduled to be discharged in spite of his weakness and poor condition. Before he could be discharged, however, he experienced chest pains and was placed on a heart monitor. The doctors concluded he had not had a heart attack and scheduled him for discharge again. He died the next morning.

The family feels strongly that the decisions concerning this case were influenced by the fact that the man was a Medicare patient. They believe, given the man's weakness and the extremity of his chemotherapy program, that he should have been kept under observation for a few days following its completion. The daughter wrote about the case so that others would know what to expect under the DRG system.

The second example of the kind of mail the Association has been receiving on the DRG system was written by a 71 year old Medicare beneficiary in Texas. She is a retired R.N., with an artificial heart valve, writing about her own unhappy experience. She was admitted to the hospital because of a high temperature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization.

After being admitted she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital inhalation therapy was required for the entire night. In addition, although she was experiencing "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

On the morning of the fourth day in the hospital her doctor announced she was going home. When she protested, he said that the hospital had a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset—even "intimidated" by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care; for such animal care the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system and learned, among other things: that the hospital has a medical review board consisting of doctors, nurses, and other hospital personnel, but (1) that, in this case, it is a medical librarian who makes the decisions about how long a patient can stay, and (2) that doctors are pressured to discharge patients as the hospital dictates.

CONTEMPORANEOUS HCFA POLICIES AFFECTING DRGS

HCFA policy decisions on the other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRGs to discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post acute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities (SNF) have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNFs to become involved in Medicare, Congress provided a mechanism for "cushioning" SNFs against wrong decisions about whether a patient is covered for SNF care. This "cushion" is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent five percent or less of the providers' Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of proposed rule, HCFA eliminates the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post acute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers' too. Beyond the waiver problem, however, home health care providers face other HCFA policies that tend to foresclose access to home care. To qualify for home health services under Medicare a patient must be "homebound" and in need of only "intermittent" care. HCFA has so restricted the definitions of "homebound" and "intermittent" care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post acute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of post acute care services necessary to accommodate Medicare patients under DRGs. Hence, Medicare patients are being discharged from hospitals into a no-care zone.

The current post acute care situation for Medicare patients can be compared to the deinstitutionalization of mental hospital patients in the 1970s. In the 1970s it was considered good public policy to close down mental hospitals and serve those patients in the community. The only problem was that we neglected to establish a community based mental health care system to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid; the unlucky ones ended up on the streets or in the criminal justice system. The Association will not sit idle while Medicare patients are forced out of hospitals still needing care and without any place to go. If policy makers cannot provide the post acute care services necessary under the incentives of the DRG prospective payment system, then it is time to change the system.

THE FEDERAL HEALTH BUDGET

The third area of concern affecting the prospective payment system is the ill-conceived federal health budget proposals from the Administration and the Senate. The Association finds little to like in any of the proposals to cut the federal health budget again this year. Most of the proposals simply shift costs to beneficaries or providers; they contribute nothing to stabilizing Medicare or the health care system.

The proposal to freeze DRG rates to hospitals at 1985 levels is particularly ill-advised considering we are in the middle of phasing-in a major change in how Medicare pays for hospital care. Freezing DRG rates is bad policy for several reasons: It is important that policy analysts understand the forces affecting behavior in the hospital sector under DRGs. To the extent that the freeze disrupts hospital behavior, it scrambles the data and makes it much more difficult to understand the cause and effect of moving to the DRG system. Moreover, the DRG system was sold on the promise that hospitals could keep the difference between the cost of delivering services and the DRG rate. Now the Administration wants to take back that difference. It is bad public policy for Congress to make promises inducing certain behavior and then to break those promises. The Congress should not be cavalier with its own reputation for veracity.

AARP RECOMMENDATIONS FOR STRENGTHENING THE DRG SYSTEM

AARP has always believed that it is possible to contain health care costs and still provide high quality health care. We continue those beliefs. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change. AARP therefore offers the following recommendations:

1. If the Congress freezes DRG rates at 1985 levels, it should also freeze the transition to the national DRG rates.

Freezing the transition to the national DRG rates is necessary to help protect those hospitals that will be "losers" under the national rates. If the transition to national rates proceeds in spite of the freeze then the "loser" hospitals will have even greater problems which, in turn, will affect patient care. Moreover, failure to halt the transition in light of the freeze would foster a two tier health care system with Medicare beneficiaries relegated to the lower tier.

2. The Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRGs. The changes should include formal hearing records and

reported decisions under Parts A and B as well as independent hearing examiners under Part B.

3. There must be a single national definition for "homebound" and for "intermittent" care. AARP favors either Senator Heinz's Home Care Protection Act, S. 778, or H.R. 2371, sponsored by Congressman Waxman.

4. AARP has long supported a severity of illness index to help adjust hospital payments to reflect high cost patients. In the absence of such an index, AARP is extremely cautious about arbitrary cuts in the allowance for indirect medical education costs. The indirect medical education costs act somewhat as a proxy for a number of factors, such as severity, which may legitimately increase costs in teaching hospitals.

5. AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. PROs must be allowed the flexibility and given incentive to be innovative—to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

6. The waiver of liability presumption for Part A providers must not be revoked.

7. To validate the numerical reduction in identified medical procedures HCFA requires of the PROs, AARP supports allocating 0.5 percent of HI revenues to study small area practice variations and feedback the information to physicians.

Thank you again, Mr. Chairman, for this opportunity to share the views of the American Association of Retired Persons on this critical area of policy.

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association, the national coordinating agency for all Blue Cross and Blue Shield Plans, appreciate the opportunity to submit this statement on Medicare's prospective payment system (PPS) for hospitals. Our comments are based on our experience both as Medicare intermediaries and carriers, and a source of private coverage for hospitalization for more than 80 million Americans.

The Subcommittee requested comments on the following issues:

1. The impact of the scheduled transition toward national DRG rates in combination with the Administration's proposed payment rate freeze, and the advisibility of delaying this transition;
2. The advisability of implementing a new wage index, and the existing law's requirement for retroactive application of a new wage index;
3. Data on higher Medicare costs associated with treating a disproportionate share of low-income patients, and the feasibility of methods for an adjustment to compensate for such higher costs;
4. Proposals to reduce or eliminate the return on equity capital now "passed through" to proprietary hospitals.
5. The adequacy of PPS adjustments for case complexity, and the relationship of case complexity to proposals to freeze payments for direct medical education costs and to reduce or modify payments for indirect medical education costs.

PROPOSED RATE FREEZE AND CONTINUED TRANSITION TO NATIONAL RATES

As stated in our April 26 testimony before this Subcommittee on the Administration's Medicare budget proposals, we believe that the proposal to freeze FY 1986 rates by regulation should be reviewed carefully to determine if it takes into account amounts "necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality," as required by current law. If a regulatory freeze fails this test, the Congress may nevertheless feel compelled, because of budget pressures, to effect a freeze by changing the law.

If Congress enacts a freeze, we believe it should be accompanied by an improvement in the accuracy of the DRG rates through the introduction of a severity of illness measure and other refinements. While these refinements are needed regardless of whether or not rates are frozen, they are particularly necessary under a freeze. Such refinements would provide a reasonable assurance that the "winners" and "losers" under the constrained payment system reflect true differences in efficiency, and are not simply the result of inaccuracies in the system. If these improvements are not technically feasible by October 1, 1985, their prompt development and implementation should be given the highest priority.

In the absence of severity adjustments and other refinements, we recommend a delay in the transition to national DRG rates corresponding to the length of the freeze. This delay would keep the hospital-specific portion of the PPS rates at 50 percent, and should compensate to some extent for the failure to include specific refinements to the system in FY 1986. Extreme changes in any individual hospital's payments should be eliminated if the transition is delayed.

IMPLEMENTING A NEW WAGE INDEX

Current law provides that PPS rates are to be adjusted for geographic differences in labor costs through use of an area wage index. The current wage index is based on data of the Bureau of Labor Statistics. In 1984, Congress directed the Secretary of HHS in consultation with the Secretary of Labor to conduct a study to develop an improved area wage index, taking into account wage differences between full and part-time workers. The Congress further directed that improvements in the index would be retroactive to cost reporting periods beginning on or after October 1, 1983.

In response to these directives, HHS conducted a hospital wage survey which included information on full and part-time employees. Data has been received from most PPS hospitals. We strongly support efforts to improve the accuracy of the current wage index, whether these efforts are based on HHS' survey or on refinements to the methods and data used by the Bureau of Labor Statistics.

However, we recommend that a new wage index not be applied retroactively. The administrative problems and expense of recalculating and recouping payments would be major as would the financial difficulties of hospitals forced to make unanticipated repayments. On the other hand, the inaccuracies of the current wage index may have resulted in significant underpayments to some hospitals. On balance, given the prospectivity of the PPS system, we think prospective application of a new index would be more appropriate.

PAYMENTS TO "DISPROPORTIONATE SHARE" HOSPITALS

In our 1983 testimony before this Subcommittee on the proposed PPS system, we expressed concern that some hospitals might be penalized because of special circumstances that the proposed system did not take into account. We were particularly concerned about essential community institutions that have higher-than-average costs for Medicare patients due to factors other than inefficiency.

Congress enacted several provisions covering these hospitals, including instructing HHS to "take into account" the special needs of hospitals serving a disproportionate share of low-income or Medicare patients. The purpose of this instruction was to respond to the concern that these hospitals necessarily incur greater costs because of the unique characteristics of their inpatients and that Medicare should recognize this situation in its payments for care received by beneficiaries. HHS has concluded that special payments to such facilities are not justified, but has suggested that an adjustment for case complexity may suffice. While an adjustment for case complexity may recognize some of these additional costs, other factors such as greater expenses for security and social services may also contribute to the higher costs of "disproportionate share" facilities. Blue Cross and Blue Shield Plans can recognize the additional special costs associated with such hospitals through flexible, negotiated payment arrangements. Our Plans generally negotiate about which costs, including special costs associated with such hospitals, will be allowed, or negotiate prices based on peer groups of similar hospitals. Since Medicare does not negotiate on such costs, we agree with ProPAC that an adjustment for "disproportionate share" hospitals should be incorporated into the system.

PROPOSALS TO REDUCE OR ELIMINATE THE RETURN ON EQUITY CAPITAL

In 1983, Congress reduced the return on equity (ROE) to proprietary providers by one-third. Congress also specified that unless it acted on capital costs for inpatient hospital services before October 1, 1986, no payments after that date could be made for such costs, including return on equity.

We believe that as Medicare continues its movement to a payment system based on price rather than costs, the need for an explicit add-on for return on equity needs to be re-evaluated. In a price-based system, return on equity is earned if a hospital operates efficiently. The conditions facing Congress and the hospital industry in 1985 have changed since Medicare was first implemented and the rationale for return on equity that had merit within a cost reimbursement system is not compelling for a price driven payment method. While we believe that the most appropriate course of action would be for Congress to review this issue as part of broader action on capital, we recognize that Congress may feel compelled to act sooner on return on equity because of short-term budgetary pressure. One option that the Subcommittee might consider is to phase-out return on equity as the PPS system continues to be phased in. We urge, however, that any short-term actions not divert attention from the need for broader reform of payment for capital.

THE ADEQUACY OF ADJUSTMENTS FOR CASE COMPLEXITY, AND THE RELATION OF COMPLEXITY TO PROPOSED REDUCTIONS FOR MEDICAL EDUCATION ACTIVITIES

We noted earlier that the highest priority should be placed on introducing severity of illness adjustments. We believe these adjustments would more accurately reflect the necessary patient care expenses incurred by teaching hospitals and "disproportionate share" hospitals, as well as refining the basis of payment for other hospitals.

We share the Administration's skepticism regarding the accuracy of the indirect medical education adjustment. Doubling the adjustment may, in fact, have only magnified its inaccuracy. However, we would be equally concerned with arbitrarily reducing the total simply by cutting it in half. We believe incorporating a severity of illness adjustment would be a more accurate and appropriate approach to recognizing necessary indirect costs of medical education activities. Implementation of an accurate severity factor would permit elimination of the indirect adjustment.

The relationship between direct medical education costs and severity of illness is more complex. Under Medicare's current pass-through method of reimbursement for these costs, the application of a severity of illness measure is not necessary. By reimbursing hospitals on a cost basis for their reasonable expenses incurred in operating a medical education program, medicare contributes toward the support of the size and scope of the teaching programs established by all hospitals, regardless of the types and severity of cases they treat.

The Administration has proposed to freeze reimbursement for direct medical education costs at the FY 1984 level. While it is possible that there is a relationship between the severity of cases treated by a hospital and its direct medical education costs, we have no data that demonstrates this. We would expect that the major effect of differences in case severity is on the indirect costs incurred by teaching hospitals, rather than on residents' salaries and related costs, which are considered direct medical education costs. While this issue should receive further study, we do not believe it is critical to the Subcommittee's consideration of a short-term freeze on direct medical education payments.

As noted in our April 26 testimony, we believe that the current method of paying for direct medical education costs should be retained, at least until a more precise method is available to isolate and pay for the costs of necessary patient care services provided by those involved in graduate medical education programs. Failure to recognize these patient costs would unfairly disadvantage teaching hospitals because those same services rendered in a non-teaching setting would otherwise be reimbursed on a fee-for-service basis under Part B of Medicare.

SUMMARY

In sum, we believe several changes are needed in the Medicare prospective payment system for hospitals:

If a statutory hospital payment freeze is enacted, Congress should delay the transition to national rates for the duration of the freeze, unless significant improvements in the accuracy of DRG rates can be made concurrently with a freeze.

The accuracy of the wage index should be improved either through use of the HHS survey data or through refinements to the BLS wage data and methods, but retroactive application of a new index should be avoided.

An adjustment for "disproportionate share" hospitals should be incorporated in the Medicare PPS system to recognize the special expenses that these hospitals incur, as recommended by ProPAC.

An explicit payment for a return on equity capital is not consistent with a price-driven payment system. One short-term option that could be considered would be to phase out the return on equity concurrent with phasing-in of the DRG rates. However, short-term actions should not divert attention from the need to consider broader reform of payment for capital before October 1, 1986.

We believe that a severity of illness adjustment would be a more accurate and appropriate approach to recognizing necessary indirect costs of medical education activities. We do not believe that incorporating a severity of illness measure is critical to the consideration of a short-term freeze on direct medical education payments. While we support a refinement in payment methods to reflect more accurately only patient-related direct education costs, we urge retention of the "pass-through" method of paying for these costs until that refinement is implemented.

We would like to thank the Subcommittee for this opportunity to express our views, and would be glad to offer any assistance on these important issues.

STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

SUMMARY

PPS rates should not be frozen.

To permit time to correct inequities, a delay in transition to national rates is appropriate.

We support use of the new wage index effective on the date that a decision about the index is made.

An HFMA task force is addressing the special problems of disproportionate share.

An HFMA task force supported "retention of existing return on equity provisions for investor-owned hospitals." (We also urge that tax-exempt financing be retained.)

A change in the indirect medical education allowance in the absence of specific recognition of differences in case complexity would be premature.

There is little alternative but to continue to fund medical education through established means.

ABOUT HFMA

The Healthcare Financial Management Association (HFMA) is a professional membership association composed of over 24,000 individuals in 74 chapters who are financial managers of hospitals and other healthcare institutions or who are closely associated with the financial management activities of healthcare providers. HFMA adopted "General Guidance Concerning Prospectively Determined Prices" on May 28, 1982. These comments are based upon that guidance and subsequent task force reports and resolutions of our organization.

RATE FREEZE

The hearing invitation treats the Administration's proposed hospital payment rate freeze as a "given." Significant reduction in Medicare spending has been achieved since the inauguration of PPS. Thus, the incentives established by this new system are achieving federal budget objectives. In letters to Congress in January and again in March, we urged that PPS rates not be frozen. We recognize the overall budget problem of the federal government and have previously offered a variety of actions that might be taken to reduce federal spending for Medicare while still preserving the incentives inherent in PPS. We continue to believe that a freeze on rates sends all the wrong signals to the industry and undermines the cooperative efforts that have characterized implementation of PPS to date.

TRANSITION TOWARD NATIONAL DRG RATES

There are a number of deficiencies in the present PPS methodology, some of which are being addressed by this hearing. Some of the current deficiencies include:

The delay in use of a relevant wage index.

The failure to recognize severity of illness.

The lack of knowledge about practice pattern differences.

The failure to consider such influences on resource consumption, other than wage rates, as location (urban/rural, core/ring, hot/cold) or age and configuration of plant.

The exclusion of provisions for patients to participate financially in their service decisions.

The effect of serving a large proportion of Medicare, Medicaid and indigent patients.

The unresolved issues from the base year; and

The lack of appeal rights.

These deficiencies in the system result in the greatest inequity when rates are based on national averages. Studies of these issues and corrective actions have been slow. HFMA urges studies and actions that will contribute to the proper evolution of PPS and improve equity of the system. Further transition toward national rates will exacerbate the inequities resulting from the current deficiencies. Accordingly, a delay in transition to national rates is appropriate.

WAGE INDEX

The wage index initially used in PPS rates is undesirable for a number of reasons. A recently completed wage survey that HFMA actively supported, corrects for some of the initial deficiencies. the index as now calculated is still far from ideal, but is an improvement. The index that excludes both physician and contract labor payments and related time is the most appropriate among the alternatives described by the Health Care Financing Administration (HFCA). HCFA has called this index "adjusted gross." We recognize, however, that the "gross index" may be more reliable and it would also be acceptable. HFMA believes that decisions about PPS rates should be made on a prospective basis. Therefore, HFMA supports the prospective application of a new wage index. It is probably most administratively feasible to make the new index applicable October 1, 1985. Since the current index contains inequities, we support use of the new wage index effective on the date that a decision about the index is made. Even though the current index contains inequities, we believe the long-range implications of retroactive application of any change in the PPS system outweighs the desirability of correcting these past deficiencies.

DISPROPORTIONATE SHARE

An HFMA task force is currently studying many aspects of uncompensated services, including the problems associated with treating a disproportionate share of low-income patients. HFMA has consistently, since the establishment of Medicare, felt that rules denying any Medicare participation in the provision of uncompensated services to be inappropriate. This inequity is most severe for the disproportionate-share hospital, but should be corrected for all hospitals. Our task force is addressing the special problems of disproportionate share. A draft report has been released for comment, but does not yet represent a position of HFMA.

RETURN ON EQUITY

An HFMA task force has studied the issue of Medicare payment for capital-related costs in connection with PPS. The task force concluded that, "a return on equity after taxes is essential to hospitals of all ownership types," but recognized that "federal Medicare spending objectives do not permit adding return on equity into prices paid to tax-exempt hospitals at this time." Accordingly, the task force supported "retention of existing return on equity provisions for investor-owned hospitals." The task force recognized that return on equity is only one of a variety of differences between tax-exempt and investor-owned hospitals, such as access to investment capital, philanthropy and the extent of use of tax-exempt financing. HFMA feels that access to capital is absolutely essential and takes this occasion to urge that tax-exempt financing be retained.

CASE COMPLEXITY

There is inadequate data available to measure and evaluate case complexity. HFMA has supported a proposed HCFA study of case coding which would identify that portion of case-mix change that is attributable to changes in coding methodology. We recently wrote to members of this committee urging their action to obtain this needed information. It is generally acknowledged that the indirect medical education allowance was intended to be a crude proxy for differences in case complexity. We support a more direct recognition of and payment for differences in case complexity, and believe a change in the indirect medical education allowance, in the absence of specific recognition of differences in case complexity, would be premature. Furthermore, PPS rates for all providers were decreased in order to provide funds to make indirect medical education payments. From the standpoint of equity, if indirect medical education payments are reduced, the funds thus saved should be restored to the average payment rates for all PPS participating providers.

MEDICAL EDUCATION

The cost of medical education must be paid for or the availability of these essential skills and their benefit to society will be diminished. Since medical education is currently being paid for on the basis of actual costs incurred by those institutions providing the services, a freeze in payments will require an immediate curtailment of expenditures at least to offset the effect of inflation. Depending upon the way in which a freeze is implemented, organizations may have to decide whether education can be continued at all. A freeze in rates will also effectively preclude any new institutions from becoming involved with medical education. Other means for paying for medical education may be consistent with sound public policy objectives, but until appropriate means for paying for medical education are devised and implemented, there is little alternative but to continue to fund this essential activity through established means. Also, the indirect medical education allowance compensates not only for case complexity, but also for essential attributes of education. Thus, it is essential to continue the indirect medical education payment to institutions engaged in direct medical education activities.

MORE INFORMATION

If you or your staff have questions on any of the views expressed above or would like to have copies of any of the studies or position statements referenced, please feel free to contact Ted Giovanis or Ronald Kovener in HFMA's Washington office. Thank you for the opportunity to present comments on behalf of our members.

STATEMENT OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE

SUMMARY OF KEY POINTS

The Association opposes a disruption in the stability and predictability of the Medicare Prospective Pricing System through implementation of a freeze in FY 1986 payments at FY 1985 levels.

The Association urges that if a freeze is adopted it be achieved through specific Congressional action and not be left to arbitrary implementation by the Department of Health and Human Services.

The Association opposes further disruption in the stability and predictability of the Medicare Prospective Pricing System which would occur if the transition to a national rate were frozen at its existing blend.

The Association supports implementation of the gross area wage index on a prospective basis beginning October 1, 1985.

The Association urges Congress to mandate implementation of disproportionate share adjustment for those hospitals serving a large Medicare and low income patient population as well as incurring substantial bad debt and charity care costs.

The Association urges that changes in the method for capital costs give due consideration to those areas of the country with an aging physical plant and that the issue of return on equity be dealt in the overall context of the treatment of capital under the prospective pricing system.

The Association opposes changes in the funding of graduate medical education until a clear federal policy on the subject is defined and developed.

Over the past several years, issues involving the role of the federal government in the delivery of health care services have been submerged into the broader debate involving the federal budget and, in particular, reduction of the federal budget deficit. The Omnibus Budget Reconciliation Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Social Security Act Amendments of 1983, and the Deficit Reduction Act of 1984 all had as their major goals a Reduction in the rate of growth in federal spending and, thus, the federal budget deficit. In achieving their goals, these same laws also set the stage for sometimes profound changes in health care delivery patterns and the way major governmental programs—such as Medicare—reimburse health care providers for services to their beneficiaries.

When enacted in 1983, as part of the Social Security Act Amendments of that year, Medicare prospective pricing—based upon diagnosis related group (DRG) method of payment per case—was intended to reorient hospital incentives allowing institutions to benefit financially from management efficiencies and increasing fiscal predictability. In addition, it was also intended that the new payment mechanism would help move toward long-term financial stability for the Medicare program.

Medicare prospective pricing is one of the major factors credited for reductions in hospital lengths of stay and staffing levels, as well as a reduction in expenditure growth, which, according to the latest statistics has leveled off to four percent a year—closely approximating the general rate of inflation. Fairness and equity for hospitals must be maintained if prospective pricing is to meet its proponents' goals. In addition, fine-tuning of the complex system will be necessary if payments are to reflect a fair market price for hospital Medicare services and design flaws are to be corrected.

Hospitals in New York State are currently reimbursed under an all-payor prospective payment system—New York's Prospective Hospital Reimbursement Methodology (NYPHRM)—established by federal waiver for the period January 1, 1983-

December 31, 1985. For a variety of reasons, it does not appear likely that our current waiver system will be extended beyond its expiration date. Present reimbursement activities in our State center around efforts to develop an equitable reimbursement system for non-Medicare payors, and to maintain a mechanism which provides coverage for uncompensated care—a major component of our current system which has proven vital in stabilizing several of our voluntary and public hospital members. These activities are based on the assumption that there will be relative stability and predictability within the Medicare prospective pricing system (PPS), as was the original intent of Congress.

MEDICARE EXPENDITURE FREEZE

At the outset, the initial concern of hospitals in New York State is a proposed Medicare expenditure freeze at fiscal year 1985 levels for payments to providers made during fiscal year 1986. When enacted in 1983, it was the intent of Congress that prospective pricing be budget neutral and that it continue the five year $20 billion in savings projected as a result of the Tax Equity and Fiscal Responsibility Act of 1982. Hospitals are currently in the second year of a four year phase-in of the new pricing system which will eventually move from a blend of hospital-specific costs and national rates to one national rate per DRG. As this transition continues inherent inequities within the system will be exacerbated as smaller portions of hospital payments are tied to past performance. Thus, the mandate for greater equity within the pricing system will become more apparent.

As hospitals gear their operations to the new system of fixed predictable prices—which is still in transition—a proposed freeze in Medicare payments at fiscal year 1985 levels raises serious questions. Though health care providers recognize the need for decisive action to reduce federal deficit spending, a freeze on payment rates could force hospitals to bear a disproportionate share of spending cuts. An arbitrary freeze on payments could result in operating deficits for hospitals, cutbacks in medical services, and limitations on access to care. In addition, a freeze would undermine the cornerstone of prospective pricing—a commitment that rates of payment would be set through a formula recognizing hospital expenses—and threaten the most promising trend in hospital costs since Medicare began.

Hospitals in New York State have operated under systems of cost control longer than those in any other part of the country, as a result savings have accured to the state and federal governments, third party payors and the general public. On a national level, in 1983, hospitals cooperated in the development and implementation of a major new payment system which is resulting in major changes in the health care delivery system. Now is not the time to disrupt the phase-in of Medicare prospective pricing through imposition of a freeze on payments.

MEDICARE TRANSITION FREEZE

At present, PPS provides for a three year transition from a price which is a blend of hospital specific costs and regional and national costs, to one that is fully based on national cost data. The transition is currently in its second year with prices based 50 percent on hospital costs and 50 percent on regional and national data. The blend is scheduled to move to a 25/75 split on October 1, 1985. Efforts are currently underway in Congress to freeze the transition at its current level based upon the assumption that such would provide additional time to make refinements in the system and enhance equity.

Our Association believes that it is necessary to make appropriate refinements in the system, we do not believe, however, that it is either necessary or appropriate to disrupt the transition to a national rate in order to make those refinements. Nor do we believe that the Department of Health and Human Services could be any more forthcoming in providing the information to Congress necessary to make refinements if the transition to a national rate were frozen at its current level. It is unfortunate that states have been categorized as winners or loser if the transition continues, in reality, all states are losers if the necessary refinements within PPS are not made. *As such, our Association opposes any efforts to freeze the current PBS transition to a national rate.*

AREA WAGE INDEX

Pursuant to the Deficit Reduction Act of 1984 (P.L. 98-369), the Department of Health and Human Services (HHS) was directed to conduct a study to develop an appropriate wage index which specifically addresses the issue of part-time employment. In addition, the same law requires that any changes made in the wage index be implemented retroactive to October 1, 1983.

Our Association strongly supports implementation of the gross area wage index outlined in HHS' March report as the most equitable in terms of its recognition of hospital labor costs. In addition, although due to our waiver New York State is not effected by retroactive implementation, we support prospective implementation of the gross area wage index effective October 1, 1985 as a means of avoiding the severe disruptions in the system which would occur through retroactive implementation.

DISPROPORTIONATE SHARE ADJUSTMENT

The original PPS law also requires HHS to make adjustments for hospitals serving a disproportionate share of Medicare and low income patients. The purpose of the adjustment is a recognition that hospitals serving a large number of low income patients have higher costs per Medicare case. To date, HHS has not implemented the disproportionate share adjustment nor have they indicated that they will.

New York State's public and voluntary hospitals provide approximately $1 billion in inpatient and outpatient bad debt and charity care a year. A portion of that loss is covered through our existing waivered system which is due to expire at the end of the year. As noted earlier, a key concern of our Association is continuation of a mechanism which addresses indigent care in the absence of our waiver.

A preliminary review of data within New York State indicates that there is a correlation between hospitals serving a disproportionate share of Medicare and Medicaid beneficiaries and the amount of bad debt and charity care incurred. In addition, many of these hospitals also would receive payments through the indirect medical education adjustment currently in place—which may be viewed as a proxy for disproportionate share hospitals.

We strongly urge Congress to mandate implementation of the disproportionate share adjustment, and would additionally suggest that one of the criterion used be those hospitals with a larger than average ratio of Medicaid patient revenues plus bad debt and charity care to total gross patient revenues.

MEDICARE EDUCATION PAYMENTS

Costs of education incurred by hospitals participating in approved training programs for the health care professions are paid under two separate provisions of the Medicare prospective pricing system. Direct education costs are not covered within prospective pricing and instead are paid for separately on the basis of reasonable costs. The rationale for the exclusion of such costs is that they are not spread evenly over all hospitals, but payment for them would be evenly spread over each of the prospective rates if they were included within prospective pricing. Some hospitals would have received funds as part of their prospective rates reflecting a category of services they do not provide, and teaching hospitals would not have received adequate payment to cover such costs.

Payments for indirect education costs are made to account for increased costs for hospitals involved in training programs—particularly physician training programs—arising from increased services to inpatients or other high costs attributable to the teaching activity of graduate medical training programs.

New York State has the highest concentration per bed of teaching hospitals in the country. This has contributed to the quality of health care in our state and—as a major training ground—the nation as a whole. It is with deep concern that hospitals within New York State look upon proposed reductions in Medicare payments for direct and indirect educational costs which would have a disproportionate impact in New York.

The Administration's budget for fiscal year 1986 proposes a 50 percent reduction in Medicare indirect medical education payments. Approximately 20 percent of the reduction over a three-year period would come from New York State. Such a reduction would have a serious effect on referral hospitals and would generally reduce the adequacy of prospective prices. The indirect education factor was created in response to inadequacies within the payment system to reflect severity of patient illness, reducing this allowance would seriously jeopardize the viability of hospitals treating disproportionately large numbers of severely ill patients.

In the area of direct payments, the Administration proposes a freeze based on prior year expenditures.

Costs in teaching hospitals are consistently higher than in their non-teaching counterparts. In addition, medical education is inextricably linked to patient care in all institutions and cannot be considered as an isolated issue. Precipitous changes in

Medicare payment policies for medical education that do not recognize that relationship must be strongly opposed by the Hospital Association of New York State.

MEDICARE CAPITAL EXPENDITURES

Under current law, capital expenses are specifically excluded from the prospective pricing system until October 1, 1986, during which time they are reimbursed on a reasonable cost basis. It is anticipated that prior to that date Congress will consider legislation folding capital into the prospective pricing system. In the event such an amendment is not adopted, Medicare payment for capital projects would be limited to those which had been approved by a section 1122 planning agency.

The capital needs of New York State's hospitals remains a continuing concern, with capital expenditures through the 1980s projected to amount to up to $10 billion. While the figure is large, the causal factors behind it must be understood. Extension of rigid hospital reimbursement systems, negative operating margins, proportionately declining philanthropy, the New York State fiscal crisis of 1975, historically increasing patient demand for hospital-based services, certificate-of-need moratoria, the building and useful life cycles of New York's medical facilities and historical undercapitalization of hospitals all have had their impact on projected capital needs. It must also be understood that the majority of applications are for correction of state and federal code violations, renovation of deteriorated facilities, and plant replacement—not expansion of beds. In effect, the New York State hospital system is attempting to halt its structural decay.

It is expected that the Administration will propose, during 1985, legislation to include Medicare payments for capital within the prospective pricing system through a uniform percentage add-on to individual DRG rates. Because the physical plant of New York State's hospitals—as well as the Northeast generally—is older than the nation as a whole, the capital needs of our facilities are greater. It is important that any proposals regarding Medicare payments for capital costs recognize the greater needs of certain parts of the country, and avoid the simplification of the issue which may be inherent through a uniform add-on.

Of additional importance to meeting the capital needs of New York's hospitals is appropriate access to the credit markets. In the past, the availability of tax exempt financing and federally guaranteed mortgages through section 242 of the FHA mortgage insurance program have played important parts in gaining that access and holding interest rates down. It is important that these two avenues of access be continued.

CONCLUSION

This statement represents a preliminary expression of the concerns of our Association with regard to Medicare prospective pricing. We urge that any actions taken by Congress this year be based upon fairness and equity and that they result in minimal disruption in the stability and predictability of the prospective pricing system.

STATEMENT OF HILDA W. HILLMAN, PRESIDENT, AND LUCY Y. STEINITZ, PH.D., EXECUTIVE DIRECTOR, JEWISH FAMILY AND CHILDREN'S SERVICE, BALTIMORE, MD

FORSAKING OUR OLDER CITIZENS

Until recently, Mrs. Lewis, age 87, lived in a small apartment on the first floor of a large house in northwest Baltimore. Following a hip injury in 1982, she had been receiving Meals on Wheels and home care. With this assistance, Mrs. Lewis continued to maintain her independence and even to attend religious services and occasional senior center activities in good weather. An elderly cousin and sister-in-law helped with food shopping, and her niece in Philadelphia called weekly. This arrangement worked well until Mrs. Lewis fell and re-injured her hip last April. With medical treatment and physical therapy, she felt better, but in October, the pain returned and progressively spread to her legs. Mrs. Lewis entered the hospital with a diagnosis of severe phlebitis. After ten days she was discharged, even though she couldn't walk and had no one to stay overnight. Mrs. Lewis fell while trying to get to the bathroom that same night. She was rushed back to the hsopital. This time she remained bedridden and, after three weeks' wait, was admitted to a nursing home. It is doubtful that Mrs. Lewis will return home again.

To some readers of Mrs. Lewis' story, this may seem an isolated incident, unrelated to their lives or those of relatives or friends. But these readers are wrong. In the near future, her tragedy could be multiplied hundreds of thousands of times across this country, in large part due to new public policy regulations that are severely impacting the health care of our older citizens.

Increasingly, hospitals nationwide have been under scrutiny to contain costs by reducing the average length of hospital stay. In a dramatic change since July 1984, Medicare now reimburses hospitals for a pre-determined number of days, based upon the patient's admitting diagnosis. These new prospective pay regulations provide a major incentive for hospitals to limit the patients' stay to the least number of days possible. More and more, treatment occurs on an outpatient basis. Occupancy rates in one Baltimore area hospital (Sinai) have fallen from around 90% to about 70% in less than two years. As a result, patients who are recovering from fractures, or who have chronic illnesses or Alzheimer's disease, or who have chosen hospice for terminal cancer are sent home in much more weakened condition than was true previously. Community-based service organizations, such as the Jewish Family and Children's Service of Baltimore, have had to pick up where hospitals are leaving off.

The population growth of older citizens, especially the frail elderly, is another factor which is eroding the ability of existing social service agencies to keep up with the demand for home care services. At the turn of the century, one in 25 Americans was over the age of 65. Now the number is one in nine, almost a 300% increase. There are more elderly people today than there are teenagers. Eleven percent of our population is ovr 65. These figures will rise dramatically to 14% or 45 million by the year 2000. Moreover, Americans are having fewer children, reducing the core of family members to help people in older age.

Family members continue to provide most of the help frail older people receive, but many pressures are making it impossible for families to carry this burden alone. More and more women are working (meaning that no adults are home during the day to give care); families are separated by long distances; and more frail older people who require care are alive today than ever before. Family caregivers find themselves calling upon community based agencies for assistance. Often, the person calling for help is over 70 and ailing. However, the requested assistance is for a sick husband or sibling, or for a mother or aunt who is in her 90's, for whom the caller feels responsible.

The frail elderly are getting short-changed. Hospitals discharge them as early as medically possible, regardless of the home environment to which they return. Medicaid reimbursements to nursing homes in Maryland have recently been changed to favor the needies patients. While this benefits those elderly requiring 24-hour nursing assistance, patients needing "intermediate" care may be hard pressed to find an available bed anywhere. Most people who enter nursing homes from the community need "intermediate" care. In desperation, many elderly and their families turn to non-profit agencies for help.

The Jewish Family and Children's Service (JFCS), a constituent agency of the Associated Jewish Charities & Welfare Fund (AJC&WF), was founded in 1856 and has provided home care and other social services to the aged since the late 19th century. Client needs are for counseling, protective housing, financial aid, assistance with caring for sick relatives, and home care. During the past year JFCS's Aged Services Department has been overwhelmed by a 2% increase in requests for service.

In our home care unit we currently serve over 300 families a month, providing assistance in bathing, dressing, meal preparation, housecleaning, and medical treatments. In the past JFCS supplied home care services primarily to aged clients who were just beginning to become frail; now very ill clients are receiving help with tube feedings, catheters, and cancer dressings. Some of these people are bedridden, and many more are confined to their homes. Without the help they receive from family and agency, many would be unable to sustain themselves in the community. Families pay on a sliding scale, and we rely on a variety of third party payment mechanisms including Medicare and Medicaid.

One of the main problems facing JFCS and other non-profit providers, however, is that third-party reimbursements seldom cover the intensity or length of service required. Neither Medicare nor private insurance pays for ongoing home care due to chronic illness. This means that families who lack the ability to purchase care in the open market are left to fend as best they can or else join the growing waiting lists of people calling not-for-profit and government agencies to request subsidized care. Other not-for-profit providers of home care in Baltimore, such as Family and Children's Society, the Department of Social Services, and the Associated Catholic Charities, have all experienced a recent increase in demand for home care. As the nation's health care dollar gets pinched, the poor inevitably feel the squeeze worse than others.

Left unchecked, the aging of our population combined with nursing home restrictions and new hospital cost-containment mechanisms will bring untold suffering to the frail elderly most in need. Under the strain, family caregivers and community agencies will inevitably fail to meet the spiraling demand placed upon them. Most critically needed are increased home support services such as home health care, respite and day treatment centers—for both acutely and chronically ill aged persons. Unless corrective action is taken to institute adequate community-based supports, we are all destined to repeat the tragedy now facing many chronically mentally ill citizens who were deinstitutionalized over the last two decades. With the promise of community-based care unfulfilled, they are left wandering the streets, begging off soup kitchens, cold and alone. In the case of the elderly, what lies before us may well be termed a deinstitutionalization movement of the physically frail. The difference is that chronic mental illness affects only 1% to 1½% of our total population, while all of us have aged relatives and will possibly one day ourselves become old and frail. Is this the future we want for ourselves and the people we love?

New Jersey Hospital Association,
Princeton, NJ, May 13, 1985.

Hon. Fortney H. Stark,
Chairman, Subcommittee on Health, House Committee on Ways and Means, Longworth House Office Building, Washington, DC.

Dear Congressman Stark: As President of the New Jersey Hospital Association (NJHA) which represents 106 New Jersey hospitals, I am writing to submit a statement to be included in the printed record of the above-mentioned hearing. Specifically, I would like to address issues related to the scheduled transition toward national DRG rates and away from hospital-specific prospective payment rates.

The NJHA is very much in favor of the transition and we believe that it should occur as now scheduled by existing law. Any delay in the implementation of DRG-specific price blending on a national level can only undermine the ultimate purpose of providing an equitable system of establishing Medicare rates for hospitals. It is incumbent upon those of us dedicated to the delivery of cost effective, quality health care to assure the realization of efficient and productive systems of management. National DRG-specific price blending is such a system.

While there are slight problem areas that remain to be resolved, as is inherent to any major change, the DRG-specific price blending approach provides significant advantages to the health care industry.

Incentives for improved hospital efficiency are an integral component of the transition especially in situations where DRGs exist with an initially wide cost distribution and must move over time toward national rates.

Various equity issues would be substantially diminished. For example, cancer hospitals, referral centers, and hospitals serving a disproportionate number of low income patients most likely have reduced needs for special treatment under a DRG-specific blending approach.

The approach itself is budget neutral in that Medicare payments are simply reallocated across hospitals.

Incentives for improved hospital performance would be maintained even after completion of the transition. Hospitals would have to: (1) Keep their Medicare costs per case below the national rate to avoid penalties on that component of the price; and (2) Keep reducing the rate of increase in their Medicare costs per case in order to achieve an operating gain on the hospital-specific component as well as the national component of the price.

It is an accepted fact that the DRG-specific price blending is administratively feasible. While the quality of collected data must be improved, the Health Care Financing Administration has the types of data and computer software needed to implement the approach. Therefore we recommend that the transition continue as scheduled in accordance with the law.

If a freeze on the transition occurs, New Jersey hospitals will face the loss of over $70 million in the first year. This will have a devastating effect and can only mean the elimination of necessary programs and services. New Jersey has maintained an historically impressive record in terms of rate of increase for both total expense per adjusted admission and total net revenue per adjusted admission. Presently, we are 51st lowest in national ranking.

I urge you to support the continuation, without interruption, of the transition to national DRG-specific rates. Furthermore, although a freeze on Medicare payments may take place, this in no way should have to affect the transition. It is certainly within the realm of Congressional legislative authority to assure the continuation of the transition, *even* if a Medicare freeze should occur.

Thank you for this opportunity to present the opinion of the New Jersey Hospital Association. I would be pleased to provide any further information that you may require.

Sincerely,

LOUIS P. SCIBETTA, FACHA,
President.

STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION

SUMMARY

As Congress considers implementing a new wage index for the Medicare prospective payment system, the Service Employees International Union believes the following issues should be taken into account:

The index currently used by HCFA has many defects: it cannot account for parttime workers and cannot measure variations in hospital occupational mix; the index in some instances encompasses too broad a labor market area.

The new proposed wage index adjusts for parttime workers, but perpetuates the other flaws in the current index and raises new questions about the indexing methods.

Both indexes exhibit large, unexplained swings in the area wage adjustment over time, raising serious questions about the stability of the area wage measurement.

No method is proposed for updating the new wage index.

When compared to other sources of wage date, both the old and the new indexes appear to contain major inaccuracies which will require further investigation.

The disruptive effects of an unstable and inaccurate wage index will continue until a sound methodological basis for the measuring and updating the index is established. We recommend the following:

A method for updating the new index at least every two years with verifiable hourly wage, fringe benefit and occupational mix data from the hospital should be established.

The stability and accuracy of the proposed wage index should be thoroughly investigated.

A new wage index should be applied prospectively.

The wage adjustment procedures should include an appeal process.

The method for collecting, verifying and updating the index should be mandated by law.

I. PROBLEMS WITH THE CURRENT INDEX

Certain defects in the Bureau of Labor Statistics (BLS) wage data for hospital workers are causing a great deal of concern about the accuracy of the current Medicare PPS wage index.

A. First, it is widely recognized that the BLS index cannot discriminate between full time and part time workers and consequently the index is unfair to hospitals that depend on a part time workforce.

B. Second, the BLS system is not sensitive to changes or differences in hospital worker mix: All hospital wages are tabulated without distinctions for various kinds of hospital occupations, even though the mix of occupations vary significantly by the size, type and location of the hospital.

For many SEIU hospitals the occupational mix has changed dramatically in recent months. For instance, we are seeing disproportionate reductions in licensed practical nurses and nurses aids compared to registered nurses. Yet, the current wage index remains insensitive to these significant changes in workforce composition.

C. Third, the magnitude and direction of error in the wage index attributable to each of these factors has never been evaluated by the Bureau of Labor Statistics or by the Health Care Financing Administration (HFCA).

D. Accuracy of the indexes geographic specifications. The wage adjustment to the PPS rate is intended to reflect the level of prevailing wages for the area in which each hospital is located. Yet, our analyses show that neither the BLS nor the new HCFA index adequately measure these area differences.

The areas on which the index is based do not match labor market areas. For example, both the old and the new wage index report a value for San Francisco that is 10% greater than that of Oakland, although the two cities are adjacent and share the same labor market. A possible 10% error rate underscores the urgent need for an accurate and verifiable index. Moreover, the 10% gap between San Francisco and Oakland seem to be unique to the HCFA indexing methods. When the indexes for these cities are compared to other sources of wage data, there are no differences between San Francisco and Oakland:

There are no differences between SEIU-bargained wage rates at San Francisco and Oakland hospitals.[1]

The U.S. Department of Labor treats San Francisco-Oakland as a one survey area in their industry wage survey.[2]

These flaws raise serious questions about the accuracy of these area measurements.

II. CONCERNS WITH THE NEW INDEX

We applaud HCFA's effort to improve the accuracy of the hospital wage index—particularly the new index's adjustment for part time workers. However, we believe that a substantial number of problems remain.

A. Stability of the New Index

The proposed HCFA index raises new questions about the stability and accuracy of the methods used to measure area wage differences.

The HCFA impact study shows that hospitals in many cities will experience huge swings between the amount they receive under the BLS wage index and the amount under the new HCFA index.

For instance, hospitals in Syracuse, New York will realize a 28% decrease in their wage adjustment under the new index system. Ten other cities will show similar swings of more than 10% up or down when the new index is applied.

These shifts must be investigated—most are not explained by the new adjustment for part time workers. Further, HFCA's impact study reports that many areas would experience dramatic changes in their wage adjustment even if the new HCFA index is not adopted. These unexplained shifts and their possible disruptive effects on hospital workers will continue until a sound basis is established for the hospital wage index.

B. How will the Index Be Updated?

The stability of the hospital wage index is further threatened by the absence of any regular way of updating the index. the new HFCA wage index was constructed from data reported on 1982 Medicare Cost Reports, supplemented by data collected from the fiscal intermediaries on a special one-time survey. Presently, there is no updating method, no time interval for updating the index and no legal requirements for hospitals to comply with the procedures. We recommend that the index must be updated at least every two years based on verifiable hourly wage, fringe benefit, and occupational mix data obtained from the hospital. In addition, these reporting requirements should not be voluntary, but required by law.

C. Allowance for "Catch-up" for Past Wage Inequities and Other Disparities Across Hospitals

The Medicare wage adjustment procedures should allow appeals based on legitimate variations in labor costs, such as catching up for past wage inequities and the higher costs of recruiting workers for jobs in which there are staff shortages.

D. Prospective Use of the New Index

Applying the new wage index retroactive to October 1, 1983 would have dire financial consequences for many hospitals and would require a complex method of reconciling overpayments and underpayments. We recommend prospective application of the new index to avoid collecting from hospitals that were overpaid under the old wage index or reimbursing those that were underpaid.

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[1] The San Franciso master agreement includes: Children's Hospital of San Francisco, Marshal Hale Memorial Hospital, Mt. Zion Hospital and Medical Center, Presbyterian Hospital of Pacific Medical Center, St. Francis Memorial Hospital, St. Mary's Hospital and Medical Center and Seton Medical Center. The Oakland hospitals included in a master agreement includes: Peralta Hospital, Providence Hospital, Samuel Merritt Hospital, Children's Hospital Medical Center of Northern California.

[2] U.S. Department of Labor, Bureau of Labor Statistics Industry Wage Survey, San Francisco-Oakland Hospitals, October, 1981.

TENNESSEE HOSPITAL ASSOCIATION,
Nashville, TN, May 23, 1985.

JOSEPH K. DOWLEY,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, DC.

DEAR MR. DOWLEY. We submit the following comments to the Subcommittee on Health as it considers the issues related to the Medicare Prospective Payment System. We represent some 170 Medicare providers, mostly hospitals, of the State of Tennessee.

Transition to national payment rates.—We wish to support the scheduled transition of the Medicare prospective payment system and we oppose any efforts to delay the move from the current 50/50 hospital specific and regional/national prices to the 25/75 percent level of hospital specific and regional/national prices.

Consider the positive elements of reduced full-time equivalent employees and the increased productivity. You must also consider the element of fiscal predictability, the grounds on which the system was accepted and promoted by the industry. Stopping the transition will severely disrupt the fiscal predictability for hospitals which have responded to the system in good faith.

New wage index and retroactive implementation.—We wish to endorse the use of a revised wage index which should be based on more accurate data, BUT retroactive implementation is inappropriate and destabilizing to the prospective payment system. Such disruption to the fiscal predictability mentioned above would mean a major population center of Tennessee would see their hospitals facing a $4 million deficit at the start of the next federal fiscal year. We recommend repeal of Section 2316(b), Public Law 98-21 prior to September 1, 1985, when HHS must publish final regulations and rates for the third year of the PPS.

With regard to the application of the wage index, the method must be improved. As it now exists, the Metropolitan Statistical Areas used to compute the index are not representative of hospital labor markets and there are gross inequities resulting. Hospitals only a few miles apart are being paid substantially differing amounts simply because of the MSA definition.

Disproportionate share of low-income patients.—It is our understanding HCFA has data which substantiates the need for an adjustment in payment to those providers caring for a disproportionately large number of low-income patients. We feel the case for this adjustment will be made by that data appropriately presented. We support such an adjustment and will work with the Subcommittee and/or the Health Care Financing Administration to identify those providers qualifying for it and would be pleased to assist in any further research which might be necessary to determine the amount of such an adjustment.

Payments for medical education, direct and indirect.—There should be little argument at this point that a major shortcoming of DRGs is failure to recognize differences of severity of illnesses. The doubling of the indirect medical education factor was some recognition of this inadequacy. To cut back in this payment will further bias the system. The teaching institutions, those which traditionally have treated the most complex illnesses, should not be subjected to further biasing by freezing and reduction of reimbursement for these respective costs.

We hope our comments here are meaningful in this summary form. We will elaborate further on any area the Subcommittee may wish addressed. The issues are so broad the Subcommittee would be inundated with paper were the details provided. As we said earlier, we stand ready to support the decision-making process in any way we can.

Sincerely,

JAMES R. ALEXANDER,
Senior Vice President.

UNIVERSAL HEALTH SERVICES, INC.,
King of Prussia, PA, May 9, 1985.

JOSEPH K. DOWLEY, Esq.,
Majority Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, DC.

DEAR MR. DOWLEY: In enacting the Medicare Hospital Prospective Payment System, Congress directed The Secretary of HHS to complete a thorough review of the methods by which capital, including return on equity, can be incorporated into the prospective payment system.

The House Ways and Means Subcommittee on Health will have budget hearings next week on the issue of whether to reduce or eliminate Medicare return on equity payments. This will drastically impact the owners of investor-owned hospitals who have invested their equity capital to finance hospital buildings and equipment used by Medicare patients.

The capital assets of investor-owned hospital industry represent billions of dollars of investment. Use of debt capital by investor-owned hospitals, which have severely restricted access to tax exempt financing, could cost the Medicare program more than it currently reimburses for return on equity.

I urge you to oppose any reduction in return on equity and to make your opposition known to all members of the Health Subcommittee. Such changes would adversely impact investment and encourage higher borrowing.

The Medicare return on equity and other capital issues are complex parts of an important area of reimbursement and should not be changed prior to careful study. Return on equity should be analyzed as part of the development of a prospective payment plan for Medicare capital payments for all hospitals.

Very truly yours,

SIDNEY MILLER,
Executive Vice President.

STATEMENT OF THE UNIVERSITY HOSPITALS OF CLEVELAND

University Hospitals of Cleveland is responding to the Subcommittees invitation to submit written testimony on Medicare Hospital Payment Issues. Our comments relate to the following issues: The impact of the scheduled transition toward national DRG rates in combination with the proposed hospital payment freeze; proposal for freezing reimbursement of direct medical education and modifying the adjustment for indirect cost of medical education; advisability of implementing a new wage index along with the issue of retroactive application of the new wage index; higher cost associated with treating a disproportionate share of low income patients and the feasibility and methodology for establishing an adjustment to compensate hospitals for higher costs.

TRANSITION PERIOD AND PRICE FREEZE

The phased transition period was included as part of the prospective payment system so that hospitals would be protected against weaknesses in the system until changes in policy could be made to correct the weaknesses. The protection is in the form of the hospital-specific payment component.

As the hospital-specific component decreases and the national average price component increases, the weaknesses in the prospective payment system become more apparent.

Two of the weaknesses in the system are: Costs of urban hospitals in New England, the Great Lakes and Pacific states are above the national averages. However, there is no evidence that these urban hospitals are less efficient than other hospitals. DRG's are not diagnoses, they are groupings of various diagnoses. Within each grouping (DRG) there are various intensities of care and levels of illness. For example, DRG 386 includes newborns with respiratory distress, resulting in an average length of stay of 4 days, and newborns weighing less than 1,500 grams (extreme immaturity) which often result in lengths of stay in excess of 50 days.

If hospitals are economically penalized for weaknesses in the system over which they have no control, there is a chance, as noted by Senator Heinz of Pennsylvania, that we may see Medicare patients being released from hospitals prematurely.

Unless the weaknesses of the system are resolved, some hospitals will be economically rewarded and other hospitals financially penalized for circumstances beyond the hospital's direct control (i.e. location or a mix of sicker patients within a DRG).

In order to neutralize the possible "windfalls" and "catastrophes", University Hospitals of Cleveland recommends the transition period be held at a 50/50 blend of hospital-specific component and a regional average price component, until the weaknesses in the system can be corrected.

University Hospitals of Cleveland also takes exception to the proposal not to consider any market basket increase in the DRG price for the third year of the Prospective Payment System.

In an economy that continues to experience inflation, it is unfair to impose a freeze on one business group which must continue to compete with other businesses for personnel, goods, and services. Hospitals have responded to the mandate to control health care cost as reflected in the HCFA statistics which reveal a decrease in hospital admissions and days. We recommend hospital DRG prices be allowed to increase as originally proposed, based on the "market basket" increase.

PAYMENTS FOR MEDICAL EDUCATION

Teaching hospitals have been able to provide a "training ground" for the development of quality physicians, nurses and allied health care professionals due to the willingness of Medicare and other payers to pay their fair share of education costs.

The proposal to freeze Medicare payments for direct medical education costs and reduce Medicare payments for indirect costs of medical education will weaken the health care manpower development programs. Teaching hospitals will not be able to devote as many resources to training qualified health care professionals, especially if other payers follow Medicare's lead and reduce support of educational programs.

A reduction in qualified health care professionals has a negative effect on the welfare of the beneficiary and the community as a whole including non-teaching hospitals. We are aware that the public policy on the financing of medical education cost is the basis of current debate. However, we recommend the issue be discussed and if appropriate, alternate solutions be reviewed and considered before altering the current policy for financing medical education. The Association of American Medical Colleges has put forward a reasonable method of determining an acceptable alternative.

It is the firm and considered recommendation of University Hospitals of Cleveland that the current pass-thru of direct education cost and the payment for indirect cost of education continue in place until an acceptable alternative is available.

REVISED WAGE INDEX

University Hospitals of Cleveland supports the efforts to develop and utilize the most accurate data for determination of the wage index used in the calculation of prospective payment rates.

We are opposed to retroactively adjusting payments to October 1, 1983. Any retroactive adjustment is inconsistent with the intent of the prospective payment system.

HCFA has ruled that if a hospital has been successful in contesting costs that were disallowed during its base year, the base year cost will be adjusted to account for the additional costs found allowable as a result of an appeal. However, insofar as the prospective payment system rates are concerned, the hospital will receive only *prospective* relief.

For example, in our Hospital's base year (1982) the Medicare cost per discharge was reduced approximately $100 due to the application of the "223 Routine Cost Limits". An exception request was filed in 1983, however a decision on our exception request was not rendered prior to the beginning of the first or second prospective payment year. The result is the hospital lost an estimated $1,100,000 in Medicare payments for the first two prospective years. After the start of the second prospective payment year HCFA rendered a decision that the Hospital's exception request was granted. DRG payment rates for the third year of PPS will reflect the additional $100 per discharge previously disallowed. However, the $1,100,000 in lost payments from the first and second prospective payment years is not recoverable.

If the wage-index is retroactively adjusted, the hospitals should also be allowed to retroactively ajust payments where the hospitals have won appeals of disallowed base-year costs.

University Hospitals of Cleveland recommends that to insure the integrity and consistency of the prospective payment system, the wage-index not be retroactively adjusted.

DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS

The 1983 Social Security Amendments direct the Secretary of Health and Human Services to provide exceptions and adjustments to take into account the special needs of hospitals who serve a disproportionate share of indigent patients. To date, the Secretary has failed to implement any exceptions or adjustments related to hospitals treating a disproportionate share to the indigent despite the recent court decision in *Redbud Hospital* v. *the Secretary,* in which the court directed the Secretary to take the necessary steps to develop an exception or adjustment methodology.

The adjustment for disproportionate share should recognize the relationship of Medicare and Medicaid revenue and bad debts and charity care to total hospital revenues. An exception or adjutment for indigent care load should be made available only to hospitals who currently do not share in local government subsidies for indigent care. It is the large private not-for-profit urban hospitals who are facing financial crises due to heavy indigent patient loads. The private hospitals do not receive the local government subsidies for indigent care that the public hospitals receive. The support of the public hospitals should remain the burden of local taxing authorities and should not be shifted to the federal government.

University Hospitals of Cleveland recommends an exception or adjustment be made available to private not-for-profit hosptials providing care to a disproportionate number of indigent patients.

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